

# HEALTH AND WELFARE BENEFITS



## THE METAL TRADES BRANCH WELFARE FUND

**Enterprise Association Metal Trades Branch**

**Steamfitters' Local Union 638**

United Association, AFL-CIO

**MARCH 2009**

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# **THE METAL TRADES BRANCH WELFARE FUND**

## **SUMMARY PLAN DESCRIPTION**

The purpose of this booklet is to provide a summary of the provisions and benefits of The Metal Trades Branch Local 638 Welfare Fund. The benefits summarized in this booklet are effective as of the printing of this document. However, the provisions of the various Plan documents govern the payment of all benefits and the full Plan documents should be consulted if you have any questions regarding your benefits. A copy of all Plan documents pertaining to the Plan are available for your inspection and copying at the Fund Office.

### ***To All Participants in The Metal Trades Branch Welfare Fund:***

The Metal Trades Branch Local 638 Welfare Fund has been designed specifically to protect the health and welfare of you and your families. The effective communication of your health and welfare benefits is a vital element in the overall success of the plan to you and to the entire group. This booklet commonly referred to as an SPD (Summary Plan Description) will describe those benefits for you.

The Trustees of The Metal Trades Branch Welfare Fund are proud of the current plan. The participants we represent can be assured of our continuing effort to further improve the plan while keeping it on a sound financial basis.

If you have any questions that are not answered by the material contained in this booklet, we encourage you to contact the Fund Office or any of the Trustees.

### ***The Trustees of The Metal Trades Branch Welfare Fund***

#### **Employee Trustees**

**John J. Torpey  
Kevin Connolly  
Richard B. Roberts**

#### **Employer Trustees**

**Jerome Morreale  
Raymond W. Hopkins  
Marc Newman  
Donald J. Steffen**

# THE METAL TRADES BRANCH WELFARE FUND

## ***Identifying the Plan:***

The full, official name of the Plan is "The Metal Trades Branch Welfare Fund," but many participants simply refer to it as the "Welfare Fund" (the "Health Plan" or the "Plan").

## ***Name, Address, Telephone Number, Web Address, and E-Mail Address of the Board of Trustees, the Plan Administrator:***

Board of Trustees  
The Metal Trades Branch Welfare Fund  
5 Penn Plaza 21<sup>st</sup> Floor  
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The Trustees as of the printing of this booklet are: Kevin Connolly, Raymond W. Hopkins, Jerome Morreale, Marc Newman, Richard B. Roberts, Donald J. Steffen and John J. Torpey.

***Employer Identification Number of the Board of Trustees:*** 13-6211854

***Plan Number:*** 501

***Plan Year Ends:*** June 30

***Type of Administration:*** Trustee Administration

## ***Agent for Service of Legal Process:***

Kevin J. Driscoll, Executive Administrator  
The Metal Trades Welfare Fund Office  
5 Penn Plaza 21<sup>st</sup> Floor  
New York, New York 10001-1887  
(212) 465-8888

***Service of legal process may also be made on any of the Trustees.***

### ***Collective Bargaining Agreement:***

The Fund is maintained pursuant to collective bargaining agreements between the Enterprise Association of Steam, Hot Water, Hydraulic, Sprinkler, Pneumatic Tube, Ice Machine, Air Conditioning and General Pipe Fitters of New York and Vicinity, Local Union 638 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada "Union" and the Mechanical Contractors Association of New York, Inc., "MCA" and other employees. Copies of these agreements may be obtained upon written request to the Fund Executive Administrator and may be examined at the Fund Office or Union Office. The Fund will provide information as to whether a particular employer is a contributing employer and, if it is, its address, once a written request for this information is made to the Fund Executive Administrator. Upon written request, a complete list of sponsoring employers or employee organizations will be provided.

### ***Source of Financing:***

The Fund is financed by contributions received from employers who employ Metal Trade Branch participants covered by a collective bargaining agreement. The amount of this contribution is determined by the agreement.

Plan assets are invested under the direction of the Trustees of the Welfare Fund.

### ***Plan Text:***

This booklet summarizes the provisions of the Welfare Plan. ***In the event of any actual or perceived conflict between the Plan documents and this booklet, the documents of the Plan will prevail.***

### ***Amendment and Termination:***

***The Trustees reserve the right to amend or terminate the Plan at any time for any reason.*** No amendment or termination will deprive a Participant, Beneficiary or Qualifying Dependent of any benefit which has already become payable under the Plan, but it could deprive them of future benefits.

***Providers of Benefits:***

**MEDICAL BENEFITS:**

- ◆ Empire HealthChoice, Inc.- Deluxe PPO

**HOSPITAL BENEFITS:**

- ◆ Empire HealthChoice, Inc.- Deluxe PPO

**PRESCRIPTION DRUG BENEFITS:**

- ◆ Medco Health Solutions, Inc.

**DENTAL BENEFITS:**

- ◆ MetLife Preferred Dentist Program (PDP)

**VISION CARE BENEFIT:**

- ◆ The Metal Trades Branch Welfare Fund

**LIFE INSURANCE & ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE:**

- ◆ Aetna Life Insurance Company

**SUPPLEMENTAL DISABILITY BENEFITS:**

- ◆ The Metal Trades Branch Welfare Fund



Please note that information on the Welfare Fund and all your benefit programs can be found on the Fund Office website.

[www.steamfitters.com](http://www.steamfitters.com)

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## ELIGIBILITY

### ***Who is Eligible for Coverage?***

All participants covered by a Collective Bargaining Agreement between their Employer and the Enterprise Association Metal Trades Branch Local Union 638 will be eligible to participate in the Plan.

### ***When Does My Coverage Become Effective?***

Participants will become eligible for coverage in the Welfare Fund on the first day of the second month following the first month his/her employer makes the required contractual contribution.

*Example: You are hired by an employer in February 2009 and reported on the employer's February report with sufficient contributions. Your coverage would start on April 1, 2009.*

The contractual contributions levels required to obtain coverage are as follows:

- ◆ MCA Service Contractors/Independent Contractors
  - one hour or more per month

[Please Note: Participants covered through an agreement with Gilmour Pipe Supply Co., Inc. are not eligible for prescription drug benefits.]

- ◆ Parkchester North, Parkchester South, Parkchester Management and Peter Cooper Village/Tishman Speyer
  - at least 130 hours per month
- ◆ Reciprocal
  - Within Local 638's jurisdiction
    - at least 100 hours per month
  - Outside Local 638's jurisdiction
    - at least 130 hours per month



- ◆ Residential Agreement Contractors
  - at least 130 hours per month

[Please Note: Residential Journeyman are covered for all health benefits. Residential Helper/Apprentices and 1<sup>st</sup> Year Helpers are only covered for Hospital and PPO benefits.]

### ***How Often Is My Coverage Reviewed?***

Eligibility for coverage in the Welfare Fund is reviewed on a monthly basis.

### ***How Do I Maintain Coverage?***

Participants will continue to be covered as long as their employers make the required monthly contributions on the participant's behalf (see necessary contribution levels in answer to "When Does My Coverage Become Effective?").

### ***When Will a Participant's Coverage Terminate?***

A participant's coverage in the Welfare Fund will terminate on the last day of the second month after the last month you are reported for.

*Example: You are last reported by an employer for the month of April 2009. Your coverage would end on June 30, 2009.*

### ***What Happens If I Lose Coverage?***

A federal law, commonly referred to as COBRA, requires that group health plans offer participants and their families whose coverage would otherwise end, the opportunity for a temporary extension of health coverage called "Continuation Coverage" at their own expense. The Welfare Fund will charge those electing COBRA coverage 102 percent of the Fund's cost of coverage.

If your loss of coverage is due to insufficient hours, you and your qualifying dependents may continue coverage for up to 36 months. Participants considering COBRA coverage must request the extended coverage in writing within 60 days from the date the participant is notified of the right to continue coverage.

If a spouse and dependents lose coverage due to the death of an active or retired participant (which is considered “insufficient hours”), COBRA continuation coverage is available for up to 36 months.

Divorced or legally separated spouses and dependent children who are no longer covered when they reach the age specified in the Plan may extend coverage for up to 36 months. If you become either divorced, legally separated or your children no longer qualify as dependents, you must notify the Fund Office in writing within 60 days to protect their COBRA rights.

Complete details concerning the COBRA coverage are available from the Fund Office.

### ***How Can I Become Covered Again?***

Once your coverage terminates, in order to become covered again, you must follow the procedures described in the answer to the question, “*When Does My Coverage Become Effective?*”

### ***What Happens to My Coverage When I Retire?***

Health coverage for a retiree is made available only for the period from Age 62 through the first of the month you become 65 (thereafter Medicare becomes available on a general basis). Please read the following two sub-sections for details.

#### ***Participants that Retire Prior to Age 62:***

If you retire prior to Age 62, you must continue your health coverage under COBRA until you attain Age 62. If you are covered under COBRA when you become Age 62, you will become eligible for health and life insurance under the Welfare Fund. If you fail to maintain your coverage under COBRA until you reach Age 62, you will forfeit any retiree coverage. Further, if you exhaust your 36 months of coverage under COBRA prior to Age 62, you will not be eligible for retiree coverage.

#### ***Participants that Retire on or after Age 62:***

If you retire and receive a benefit from the Pension Fund and were covered the day before your pension effective date (by virtue of employment or COBRA) you will be eligible for health and life insurance coverage.

All coverage in the Welfare Fund for retired participants and the dependents of retired participants will terminate as of the first of the month that the dependent or retired participant becomes 65. However, an eligible dependent, who has not yet attained age 65 and who loses coverage based on the retired participant’s loss of coverage may elect to continue health coverage through COBRA.

## ***What Happens If An Active Participant Becomes Temporarily Disabled and Unable to Work?***

If an active covered participant becomes temporarily disabled and unable to work, the participant and all eligible dependents will continue to be covered during the period in which the participant is disabled up to a maximum of six months in any twelve month period providing the participant furnishes timely notice and medical proof of such disability. If the participant is still disabled after six months, the participant may continue health benefits for themselves and their dependents by making the required COBRA payment for a maximum period of up to thirty-six months. (Please refer to the COBRA section of this booklet for details.)

Disabled participants who elected to continue their health benefit by making the required COBRA payment, and who subsequently qualify for Medicare during such thirty-six month period, shall lose their coverage under COBRA rules. However, they will be permitted to continue to make COBRA payments for their dependents for the remainder of the self-payment period.

## ***What Happens If I Enter the Uniformed Services?***

If you are drafted, activated from reserve status or enlist into the Uniformed Services of the United States (which includes the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service commissioned corps, the Army National Guard and Air National Guard), your coverage as an active participant will terminate in accordance with regular eligibility rules (see "When Will a Participant's Coverage Terminate"). However, if you were a covered participant on the date of your entry, the following is applicable:

- ◆ If you are on active military duty for 30 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).
- ◆ If you are on active duty for more than 30 days, USERRA permits you to continue medical, prescription and dental coverage for you and your dependents at your own expense for up to 24 months provided you enroll for coverage. This continuation of coverage operates in the same way as COBRA. (Please refer to the COBRA section of this booklet for details.) In addition, your dependents may be eligible for health care under the Civilian Health & Medical Program of the Uniformed Services (TRICARE). This Plan will coordinate coverage with TRICARE if your dependents are enrolled in COBRA with the Welfare Fund (see the "Coordination of Benefits" section of booklet.).

- ◆ When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating employer, based upon time spent on military duty according to the following schedule:
  - At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and additional eight hours) if the period of service was less than 31 days.
  - 14 days from the date of discharge, if the period of military service was 31 days or more, but less than 181 days (assuming you either returned to work or applied for employment with a signed employer).
  - 90 days from the date of discharge, if the period of military service is more than 180 days (assuming you either returned to work or applied for employment with a signed employer).

If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Please contact the Fund Office for more details.

### ***Are All Of My Family Members Eligible For the Plan's Coverage?***

Your legal spouse is eligible for coverage through the Welfare Fund. Your spouse will lose coverage on the day after the date of a divorce or legal separation is effective.

Your ***unmarried*** children will be considered qualifying dependents and eligible for coverage through the Welfare Fund in accordance with the following:

- A) the child has not completed the end of the calendar year during which they became 19, or
- B) the child has completed the end of the calendar year during which they became 19, but has not completed the end of the year during which they became 23, is primarily dependent on you for financial support and attends an accredited institution of higher education or other institution offering degree or certificate upon program completion on a full-time, day student basis as his or her principal activity. (The term "full-time student" will mean being registered for not less than 12 course credits per semester. If the institution establishes full-time status by a method other than semester credit hours, the Fund reserves the right to determine whether the student qualifies as a dependent.), or

- C) children who complete the end of the calendar year during which they became 19 remain covered if they are incapable of self-support because of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law) or physical handicap provided the incapacitating condition started before dependent status would otherwise have ended. To continue coverage beyond age 19, an "Affidavit of Dependency for Mentally or Physically Handicapped Children", which includes proof of incapacitation from the dependent's physician or physicians, must be submitted. Proof of incapacitation must be submitted to the Trustees as often as requested. An independent examination must be permitted if the Trustees so request. In addition, proof of dependent status from the Internal Revenue Service income tax filings must be made available to the Trustees as often as so requested. The affidavit must be filed with the Trustees **prior** to the date such a child attains age 19 in order to qualify for continuance of coverage.

If your child is employed where other group coverage of a non-contributory nature is available, the Welfare Fund provides secondary coverage only.

The term "children" will include:

- ◆ your own or legally adopted children,
- ◆ children in your custody while awaiting final legal adoption,
- ◆ your stepchildren who are primarily dependent upon you for financial support, (an Affidavit of Dependency must be completed), and
- ◆ any other children related to you by blood or marriage who live with you in a regular parent-child relationship and are primarily dependent upon you for financial support (an Affidavit of Dependency must be completed).

**Excluded:** Parents, grandparents, nieces, nephews or grandchildren, even though they may reside in the participant's household and be dependent upon the participant for support and maintenance, are **not** covered under the Plan.

***It is essential that any changes in family status (marriage, birth, death, adoption, etc.) be reported in writing to the Fund Office. Failure to do so can delay or prevent payment of your claims.***

### ***What Happens To My Family's Health Coverage If I Die?***

Upon the death of a covered participant, active or retired, the coverage for the surviving spouse and any dependent(s) terminates as of the member's death date. (see answer to "What Happens If I Lose Coverage?" regarding dependent COBRA coverage for dependents of deceased participants.)

## **OVERVIEW OF HEALTH CARE PROVISIONS**

The Metal Trades Branch Welfare Fund provides several types of health care benefits:

- ◆ Hospital and Medical Benefits
- ◆ Dental Care Benefits
- ◆ Prescription Drug Benefits
- ◆ Vision Care Benefits

The above benefits are administered by either the Welfare Fund or by outside organizations designated by the Trustees.

## **HOSPITAL AND MEDICAL BENEFITS**

Hospital and Medical Benefits are provided by Empire Health Choice, Inc. under the Deluxe PPO product. A full and complete description of the hospital and medical benefits available are contained in the blue-colored pages of this book.

# PRESCRIPTION DRUG BENEFITS

## ***Who Administers The Prescription Drug Benefits?***

Prescription drug benefits are available to all participants and their qualifying dependents who meet the Welfare Fund eligibility requirements. Your prescription drug benefits are administered by **Medco Health Solutions, Inc.** which covers almost all drugs prescribed by a licensed medical doctor, osteopath, dentist or podiatrist for their generally accepted medical use.

This benefit includes both a Card Program and a Home Delivery/Mail Service Program. This benefit program was instituted in an effort to increase benefits, alleviate the claim filing burden and reduce costs when you or your dependents require prescription drugs. At the time your coverage becomes effective you will receive a plastic identification drug card and home delivery/mail service order forms.

## ***How Does The Prescription Drug Benefit Program Work?***

The Prescription Drug Benefit works through the following three components: the Card Program, the Home Delivery/Mail Service Program and a Direct Reimbursement Program. These components are further explained in this section.

### **❖ CARD PROGRAM**

Whenever you need to fill a prescription at a local pharmacy, all you will have to do is present your Medco identification card and make a small co-payment. The co-payments for each prescription will be \$5.00 for generic drugs, \$15.00 for brand name drugs and \$22.00 for controlled substances. You can receive up to a 21 day supply of your medication and one refill for the same number of days. A 30 day fill will be permitted for controlled substances only. Although no limit in terms of refills for controlled substance, the law requires a prescription for each re-order. Beyond that, you *must* use the Home Delivery/Mail Service Program.

### **❖ HOME DELIVERY / MAIL SERVICE PROGRAM**

If you or any of your dependents need medication on an on-going basis (maintenance drugs), you *must* fill those prescriptions through the Home Delivery/Mail Service Program, commonly called *Medco By Mail*. Prescriptions filled through the Home Delivery/Mail Service Program are subject to a \$30 co-payment. The drugs are delivered to your home, postage paid. Your physician can prescribe up to a 90-day supply with refills, of the medication you need.



You will then submit your prescription and claim form to the home delivery/mail service pharmacy for dispensing. If you require a refill, just notify the home delivery/mail service pharmacy by mail, telephone [(800) 445-9707], or through the internet ([www.medcohealth.com](http://www.medcohealth.com)).

No claim forms are required for prescriptions obtained through the card or home delivery/mail service program.

#### ❖ **DIRECT REIMBURSEMENT PROGRAM**

Should there arise an occasion that the retail or home delivery/mail service program is not used, a *direct reimbursement claim* process has been established between the Welfare Fund and Medco. Your reimbursement under this program may be significantly less than your purchase price of the prescription. Participants are permitted to use the direct reimbursement claim procedure only once during their lifetime coverage.

Contact the Fund Office [(212) 465-8888 extension 244] to obtain a Direct Reimbursement Claim form. The claim form must be filled out by the patient as well as the pharmacist. Along with the complete claim form, you must submit a letter explaining why you were unable to use the card or the home delivery/mail service program to the Fund Office. Upon the approval of the Fund, your claim will be submitted to Medco for processing.

### ***What Prescription Drugs Are Covered In This Program?***

Prescription drugs available under both the Card and the Home Delivery/Mail Service Programs include:

- ◆ Federal Legend Drugs
- ◆ State-Restricted Drugs
- ◆ Compounded Medications
- ◆ Insulin and insulin syringes only
- ◆ Narcotic painkillers (considered controlled substances)
- ◆ A.D.D. drugs (considered controlled substances)

Each state establishes its own legal list of controlled substances. Typically, under state laws, a controlled substance cannot have more than a 30 day fill.

## ***Are There Any Exclusions In This Program?***

The following are the excluded items to the prescription plan:

- ◆ Contraceptives, oral or other, whether medication or devices, regardless of intended use.
- ◆ Non-Federal Legend Drugs including all "over the counter" items, regardless of whether they are prescribed.
- ◆ Charges for the administration or injection of any drug.
- ◆ Needles and syringes, support garments, and other non-medical substances (such items may be covered under your medical benefits coverage).
- ◆ Prescriptions which you are entitled to receive without charge under any Workers' Compensation Laws or any municipal, state or federal program.
- ◆ Medication taken by, or administered to, a person while an inpatient in a licensed hospital, hospice, rest home, sanitarium, extended care facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceutical products.
- ◆ Drugs labeled "Caution - limited by federal use to investigational use" or experimental drugs.
- ◆ Blood, blood plasma or biological sera.
- ◆ Vitamins; except those, which by law, require a prescription.
- ◆ Any prescription filled, except controlled substances, in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

## ***What Programs Have Been Instituted to Insure Proper Drug Use?***

The Welfare Fund is committed to providing quality prescription drug benefits. With this goal in mind, we use a set of Utilization Management Programs, administered by Medco, to determine how your prescription drug plan will cover certain medications. The goal of these programs is to alleviate inappropriate and potentially harmful use of prescription drugs while simultaneously assuring the proper utilization of benefit dollars. Member health, safety, and satisfaction remain the primary objectives of the prescription drug coverage.

These programs are Coverage Review, Step Therapy, Quantity Duration and Retrospective Drug Utilization Review (RDUR) health and safety program.

## Coverage Review

For some medications, you must obtain approval through a review process in order to obtain coverage. When you use Medco By Mail, we will call your doctor to start the coverage review. If you submit a prescription to a participating retail pharmacy for a medication that requires coverage review, you, your doctor, or your pharmacist can initiate the review by calling ((800) 753-2851).

If coverage is not approved, either at a retail or mail-order basis, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request the appeal will be included in the letter that you receive.

The following medications are subject to a Coverage Review:

Androgens and anabolic steroids (androgens: methyltestosterone tablets and capsules, fluoxymesterone tablets, testosterone gel, testosterone patches, testosterone lozenges, injectable testosterone, and injectable methyltestosterone; anabolic steroids: *Anadrol-50*<sup>®</sup>, *Winstrol*<sup>®</sup>, *Oxandrin*<sup>®</sup>, *Deca-Durabolin*<sup>®</sup>, and *Kabolin*<sup>®</sup>)  
Growth hormones (*Humatrope*<sup>®</sup>, *Nutropin*<sup>®</sup>, *Serostim*<sup>®</sup>, *Saizen*<sup>®</sup>, *Norditropin*<sup>®</sup>, *Genotropin*<sup>®</sup>, *Tev-Tropin*<sup>®</sup>, *Zorbtive*<sup>™</sup>, *Protropin*<sup>®</sup>, *Increlex*<sup>™</sup>)  
Appetite and weight loss (*Meridia*<sup>®</sup>, *Xenical*<sup>®</sup>, *Didrex*<sup>®</sup>, diethylpropion, *Tenuate*<sup>®</sup>, phentermine, *Ionamin*<sup>®</sup>)  
Miscellaneous pulmonary agents (*Xolair*<sup>®</sup>)  
Hepatitis medications: interferons (*Infergon*<sup>®</sup>, *Roferon*<sup>®</sup>, *Intron*<sup>®</sup>-A, *Alferon*<sup>®</sup>, *PEG-Intron*<sup>®</sup>, *Pegasys*<sup>®</sup>); ribavirin (*Rebetol*<sup>®</sup>, *Copegus*<sup>®</sup>)  
Antinarcotic agents (*Provigil*<sup>®</sup>)  
Antineoplastic agents (*Iressa*<sup>®</sup>)  
Contraceptive agents (various)  
Erythroid stimulant (*Epogen*<sup>®</sup>, *Procrit*<sup>®</sup>, *Aranesp*<sup>®</sup>)  
Miscellaneous dermatologicals (*Retin-A*<sup>®</sup>, *Tazorac*<sup>®</sup> cream)  
Multiple sclerosis therapy (*Avonex*<sup>®</sup>, *Rebif*<sup>®</sup>, *Betaseron*<sup>®</sup>, *Copaxone*<sup>®</sup>)  
Myeloid stimulants (*Neupogen*<sup>®</sup>, *Leukine*<sup>®</sup>, *Neumega*<sup>®</sup>, *Neulasta*<sup>®</sup>)

## Step Therapy

Step Therapy looks at a patient's prescription history and determines whether he or she is eligible for a given medication without a coverage review. If there is not enough information in the history, a coverage review may be necessary. The following medications are subject to a Step Therapy Review:

Miscellaneous rheumatologicals (*Enbrel*<sup>®</sup>, *Arava*<sup>®</sup>, *Kineret*<sup>®</sup>, *Humira*<sup>®</sup>, *Orencia*<sup>®</sup>, *Remicade*<sup>®</sup>)  
Pain (*Oxycontin*<sup>®</sup>, *Actiq*<sup>®</sup>)  
Dermatologicals (*Protopic*<sup>®</sup>, *Elidel*<sup>®</sup>)  
Allergy (*Singular*<sup>®</sup>, *Accolate*<sup>®</sup>, *Zyflo*<sup>®</sup>)  
Cancer Therapy (*Tarceva*<sup>®</sup>)  
COX 2 inhibitors (*Celebrex*<sup>®</sup>)  
Ribavirin therapy (*Rebetol*<sup>®</sup>, *Copegus*<sup>®</sup>)

## Quantity Duration

Your prescription drug plan provides coverage for a quantity of medication and duration of treatment sufficient to meet the needs of most patients. If a greater quantity or longer course of treatment is needed, a coverage review process is required.

The following medications are subject to a Quantity Duration Review:

Sleep therapy (Lunesta<sup>®</sup>, Ambien<sup>®</sup>, Sonata<sup>®</sup>, Prosom<sup>®</sup>, Doral<sup>®</sup>, Restoril<sup>®</sup>, Dalmane<sup>®</sup>, Halcion<sup>®</sup>, temazepam, flurazepam, triazolam)  
Erectile dysfunction agents (Cialis<sup>®</sup>, Levitra<sup>®</sup>, Viagra<sup>®</sup>, Caverject<sup>®</sup>, Edex<sup>®</sup>, and Muse<sup>®</sup>)  
Migraine therapy (Imitrex<sup>®</sup>, Zomig<sup>®</sup>, Axert<sup>®</sup>, Amerge<sup>®</sup>, Frova<sup>®</sup>, Relpax<sup>®</sup>, Maxalt<sup>®</sup>, Migranal<sup>®</sup>)  
Anti-influenza (Relenza<sup>®</sup>, Tamiflu<sup>®</sup>)

## Quantity Duration – no review

Your plan will cover the following 8 pills of the medications listed below within a 21-day period. Prescriptions that exceed that amount will not be covered by the plan. Your retail pharmacist or your mail-order pharmacy may reduce the quantity of medication dispensed to an amount covered by your plan. If you choose to obtain additional quantities, you will be responsible for the full cost of the medication at your retail pharmacy.

Erectile dysfunction agents (Cialis<sup>®</sup>, Levitra<sup>®</sup>, Viagra<sup>®</sup>, Caverject<sup>®</sup>, Edex<sup>®</sup>, and Muse<sup>®</sup>)

## Retrospective Drug Utilization Review health and safety program

Medco may provide information to your doctor about potential prescribing or medication utilization issues. These include situations in which similar and overlapping medications appear to have been prescribed for the same condition, or when medications may interact with each other in a way that could be harmful to your health.

The information we provide to your doctor is intended to help ensure that you get the safest and most effective therapy possible, especially when more than one doctor is involved in your care. A change in your prescription(s) can sometimes result from these communications between Medco and your doctor.

The specific drugs listed above in the Utilization Management Programs are updated on a regular basis. Contact the Medco toll free number [(800)753-2851] with any questions regarding a drug's participation in the Utilization Management Programs.

# DENTAL EXPENSE BENEFITS

***METLIFE PREFERRED DENTIST PROGRAM (PDP)***

The following benefits are provided to all eligible Welfare Fund participants and their qualifying dependents subject to the provisions of the program.

**SCHEDULE OF BENEFITS**

**DENTAL EXPENSE BENEFITS**

***DEDUCTIBLE AMOUNT***

For Services of Network Providers.....	None
For Services of Non-Network Providers	
Type A, B, C and/or D Expenses Combined	
Individual .....	\$100
Family .....	\$200

***COVERED PERCENTAGE***

**For Services of Network Providers**

Type A Expenses.....	100%
Type B Expenses.....	100%
Type C Expenses.....	100%
Type D Expenses.....	75%

**For Services of Non-Network Providers**

Type A Expenses.....	80%
Type B Expenses.....	80%
Type C Expenses.....	60%
Type D Expenses.....	50%

[When a Non-Network Provider is used, the covered expenses are based on the MetLife PDP network schedule of benefits.]

***MAXIMUMS***

For Orthodontic Treatment	
Aggregate Maximum Benefit	
Lifetime per covered dependent child.....	\$3,000
For Other Covered Dental Expenses	
Maximum Benefit	
Per Calendar year.....	\$3,000

## PLEASE NOTE:

- ◆ Expenses for orthodontia, including any procedures necessary for such treatment, will be considered covered dental expenses only if the dependent child has not reached age 19 (age 23, if a full-time student).
- ◆ Covered dental expenses for orthodontia are not included in the Maximum Benefit per calendar year.
- ◆ The maximums for both orthodontic treatment and all other covered dental expenses apply to all expenses incurred whether treatment is provided by a Network Provider, a Non-Network Provider or a combination thereof.
- ◆ If a dental bill is expected to be \$300 or more, see section F, Predetermination of Benefits.

## DENTAL EXPENSE BENEFITS

### A. DEFINITIONS

**Covered Dental Expense** means the charges based on the Preferred Dentist Program Schedule of Maximum Payments for the types of dental services shown in section C. These services must be:

1. performed or prescribed by a dentist who is:
  - a Network Provider; or
  - a Non-Network Provider; and
2. necessary in terms of generally accepted dental standards.

There may be more than one way to treat a dental problem. If, in MetLife's view, an adequate method or material which costs less could have been used, the dental expense benefits will be based on the method or material which costs less. The balance of the cost will not be a covered dental expense. See section E for examples that show how this works.

**Dentist** means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a doctor will be considered for dental expense benefits as if it were performed or prescribed by a dentist.

**Deductible Amount** means the amount shown in the Schedule Of Benefits. The deductible amount during any one calendar year will not apply to covered dental expenses after:

1. you incur covered dental expenses for covered persons in your family;  
and
2. those expenses, when applied to the deductible amount, equal the family deductible amount.

**Covered Percentage** means the percentage shown in the Schedule Of Benefits.

**Preferred Dentist Program Schedule of Maximum Payments** means MetLife's fee agreement with a Network Provider in which such Network Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

**Preferred Dentist Program** means MetLife's program to offer a covered person the opportunity to receive dental care from dentists who are designated by MetLife as Network Providers. When dental care is given by Network Providers, the covered person will generally incur less out-of-pocket cost for the services rendered.

**Network Provider** means a dentist who has been selected by MetLife for inclusion in the Preferred Dentist Program. These Network Providers agree to accept the Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

**Non-Network Provider** means a dentist who is not a Network Provider.

**Preferred Dentist Program Directory** means the list which consists of selected dentists who:

- ◆ are located in the covered person's area; and
- ◆ have been selected by MetLife to be Network Providers and part of the Preferred Dentist Program. These Network Providers agree to accept our Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

## **B. COVERAGE**

### **1. When Benefits May Be Payable**

MetLife will pay dental expense benefits if you incur covered dental expenses:

- ◆ for a covered person during any calendar year; and
- ◆ while you are covered for the dental expense benefits for that covered person; and
- ◆ the covered dental expenses are more than the deductible amount when using Non-Network Providers.

An expense is "incurred" on the date the dental service is completed.

### **2. How Benefits Are Determined**

Benefits will be equal to the covered percentage of those covered dental expenses which are more than the deductible amount. However:

- ◆ The sum of all benefits for all covered dental expenses incurred for a covered person during any calendar year will not be more than the maximum benefit per calendar year; and
- ◆ The sum of all benefits for all covered dental expenses incurred for a covered person for orthodontic treatment during all calendar years will not be more than the applicable Aggregate Maximum Benefit.

In order to determine the amounts of covered dental expenses, MetLife may ask for x-rays and other diagnostic and evaluative materials. If they are not submitted, MetLife will determine covered dental expenses on the basis of the information which is available. This may reduce the amount of benefits which otherwise would have been payable.

### **3. How the Preferred Dentist Program Works**

A covered person is always free to choose the services of a dentist who is either:

- ◆ a Network Provider; or
- ◆ a Non-Network Provider.

Benefits will be determined and paid in either case, except that the covered person will generally incur less out-of-pocket cost if a Network Provider is chosen.



## **C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES**

### **1. Type A Expenses**

- a. Oral exams
- b. X-rays:
  - ◆ full mouth x-rays but not more than once every 36 months.
  - ◆ bitewing x-rays but not more than twice in any calendar year (every 183 days).
- c. Preventive treatment:
  - ◆ cleaning and scaling of teeth (oral prophylaxis) but not more than twice in any calendar year; and
  - ◆ topical fluoride treatment for a dependent child until their 19th birthday, but not more than twice in any calendar year.
- d. Space maintainers for a dependent child through the year in which they turn 19 (age 23 if a full-time student).
- e. Two applications of sealant material for each molar tooth of a dependent child under age 16 not more than twice in a lifetime.
- f. Emergency palliative treatment.

### **2. Type B Expenses**

- a. Fillings - amalgam, silicate, acrylic, synthetic porcelain or composite fillings.
- b. Extractions
- c. Root canal treatment
- d. Treatment of periodontal disease and other diseases of the gums and tissues of the mouth.
- e. Oral surgery
- f. Injections of antibiotic drugs
- g. Administration of general anesthesia, when medically necessary in connection with oral surgery, extractions, or other covered dental services.
- h. Relinings and rebasings of existing removable dentures, but not more than once in any 36 month period.
- i. Repair or re-cementing of crowns; inlays or onlays; dentures; or bridgework.

### 3. Type C Expenses

- a. Those services needed to replace one or more natural teeth which are lost while dental expense benefits for the covered person are in effect for:
  - ◆ Installation of fixed bridgework done for the first time.
  - ◆ Installation for the first time of a partial removable denture or a full removable denture.
- b. Replacing an existing removable denture or fixed bridgework if it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed or it is needed because the existing denture or bridgework can no longer be used and the existing denture or fixed bridgework was installed at least 60 months prior to its replacement.
- c. Replacing an existing immediate temporary full denture by a new permanent full denture when the existing denture cannot be made permanent; and the permanent denture is installed within 12 months after the existing denture was installed.
- d. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.
- e. Inlays, onlays, and crown restorations, but not more than one such restoration to the same tooth surface within 60 months of the prior restoration.

### 4. Type D Expenses

Orthodontia, including appliance therapy for dependent children through the year in which they turn age 19 (age 23, if a full-time student). The Aggregate Maximum Benefit for orthodontia is shown in the Schedule Of Benefits.

## **D. EXCLUSIONS: SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES**

1. Services or supplies received by a covered person before the dental expense benefits start for that person.
2. Services not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
  - ◆ cleaning and scaling of teeth; or
  - ◆ fluoride treatments.
3. Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
  - ◆ it otherwise is a covered dental expense; and
  - ◆ it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
  - ◆ it is required for reconstructive surgery because of a congenital disease or anomaly of a dependent child which has resulted in a functional defect.
4. Replacement of a lost, missing or stolen crown, bridge or denture.
5. Repair or replacement of an orthodontic appliance.
6. Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
7. Services or supplies which are covered by any employers' liability laws.
8. Services or supplies which any employer is required by law to furnish in whole or in part.
9. Services or supplies received through a medical department or similar facility which is maintained by the covered person's employer.
10. Services or supplies received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person.
11. Services or supplies for which a covered person is not required to pay.

12. Services or supplies which are deemed experimental in terms of generally accepted dental standards.
13. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect.
14. Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
15. Any duplicate appliance or prosthetic device.
16. Use of materials to prevent decay other than fluorides and sealant material for the molar teeth of a dependent child under age 16.
17. Instruction for oral care such as hygiene or diet.
18. Periodontal splinting.
19. Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan which the employer (or an affiliate) contributes to or sponsors.
20. Myofunctional therapy or correction of harmful habits.
21. Implantology.
22. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the dental expense benefits started for the covered person.
23. Charges for broken appointments.
24. Charges by the dentist for completing dental forms.
25. Sterilization supplies.
26. Services or supplies furnished by a family member.
27. Treatment of temporomandibular joint disorders.

**Dental expenses will be based on the materials and method of treatment which cost the least and which, in MetLife's view, meet generally accepted dental standards.**

## ***E. EXAMPLES OF ALTERNATE BENEFITS***

### **1. Fillings: Inlays, Onlays and Crowns**

If a tooth can be repaired by a less costly method than an inlay, onlay or crown, dental expense benefits will be based on the adequate method of repair which costs the least.

### **2. Crowns, Pontics, and Abutments**

Veneer materials may be used for front teeth or bicuspid. However, dental expense benefits will be based on the adequate veneer materials which cost the least.

### **3. Bridgework and Dentures**

Dental expense benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental expense benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your dental expense benefits will be, see section F.

## ***F. PREDETERMINATION OF BENEFITS***

If a dental bill is expected to be \$300 or more, before the dentist starts the treatment, a covered person can find out what dental expense benefits will be paid by MetLife. To do this, the covered person should send a claim form to MetLife in which the dentist states:

- ◆ the work to be done; and
- ◆ what the cost will be.

MetLife will then tell the covered person what the dental expense benefits schedule is. The predetermination does not review eligibility for services which have time limitations, ex. dentures cannot be replaced within 5 years of installation. If the covered person does not use this method to find out what dental expense benefits MetLife will pay, the decision will be final and binding with regard to what are covered dental expenses and what dental expense benefits will be paid.

This method should not be used for:

- ◆ emergency treatment; or
- ◆ routine oral exams; or
- ◆ x-rays, cleaning and scaling, and fluoride treatments: or
- ◆ dental services which cost less than \$300.

### ***G. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS***

To the extent that services or supplies, or benefits for them, are available to a covered person under a government plan, as defined below, they will not be considered for dental expense benefits under this benefit program. This provision will apply whether or not the covered person is enrolled for all government benefits for which they are eligible. This provision will not apply to a government plan if it requires that dental expense benefits under this benefit program be paid first.

A government plan is any plan, program or coverage, other than Medicare:

- ◆ which is established under the laws or the regulations of any government; or
- ◆ in which any government participates other than as an employer.

### ***H. DENTAL EXPENSE COVERAGE AFTER BENEFITS END***

No benefits will be payable for covered dental expenses incurred by a covered person after the dental expense benefits for that person end. This will apply even if we have pre-determined benefits for dental services. However, benefits for covered dental expenses incurred for a covered person for the following services will be paid after dental expense benefits end:

1. For a prosthetic device if:
  - ◆ the dentist prepared the abutment teeth and made impressions while dental expense benefits for the covered person were in effect; and
  - ◆ the device is installed within 60 days after the date the dental expense benefits end; or

2. For a crown if:
  - ◆ the dentist prepared the tooth for the crown while the dental expense benefits for the covered person were in effect; and
  - ◆ the crown is installed within 60 days after the date the dental expense benefits end; or
3. For root canal therapy if:
  - ◆ the dentist opened the tooth while the dental expense benefits for the covered person were in effect; and
  - ◆ the treatment is finished within 60 days after the date the dental expense benefits end.

### ***I. PAYMENT OF BENEFITS***

MetLife will send payment directly to your Network Provider. When a Non-Network provider is used, dental expense benefits will be paid to you. MetLife will pay benefits when it receives satisfactory written proof of your claim. Proof must be submitted not later than 90 days after the end of the calendar year in which the covered dental expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the proof is given as soon as possible.

### **WHEN BENEFITS END**

- ◆ All of your benefits will end on the date your coverage in the Welfare Fund ends. Your coverage ends when you fail to maintain eligibility. Please refer to the **ELIGIBILITY** section for details.
- ◆ If this benefit program ends in whole or in part, your benefits which are affected will end.
- ◆ All benefits on account of a qualifying dependent will end on the last day of the calendar year in which that qualifying dependent ceases to be your dependent.

The end of any type of benefits on account of a covered person will not affect a claim which is incurred before those benefits ended.

The dental expense benefits for a covered person may be continued in accordance with the federal law called COBRA. Please refer to the answer to the question "***What Happens If I Lose Coverage?***" under the **ELIGIBILITY** section of this booklet for details.

## VISION CARE BENEFITS

### ***What vision care benefits does the plan offer?***

Vision care benefits are available for you and your qualifying dependents. This benefit will reimburse you for the cost of eye examinations, frames, and/or lenses, including contact lenses and prescription sunglasses. LASIK, LASEK, PRK and similar procedures are considered to be cosmetic procedures and are not covered. Non-prescription sunglasses are also excluded from this program.

Vision care benefits are available in the maximum amount of \$200 per person each calendar year. You must be covered under the Welfare Fund on the date of service or the purchase date. In addition, the date of service or the purchase date will determine whether you have reached the maximum benefit for the year. Claims must be filed within a twelve-month period following the date services were provided. Failure to file proof of claims within the required time period shall result in a forfeiture of benefits.



## COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a provision in group health and group dental contracts that prevent duplicate payments for the same covered medical or dental expenses. The COB provision applies only when a participant or eligible dependent is covered under more than one group health or dental program. When that is the case, the Welfare Fund will coordinate benefit payments with the other group plan. One group will pay its full benefit as the primary plan and the other group will pay secondary benefits (if necessary) to cover some or all of the remaining expenses. This COB provision prevents duplicate payments and overpayments. In no case should the benefits received from the two group plans in total be greater than the medical or dental *allowed* charges.

The rules to determine the order of payment under Welfare Fund coverage in those cases where there is coverage under more than one group plan are as follows:

- A) If the other group plan does not have a COB provision similar to the Welfare Fund's, then that group will be primary.
- B) If both groups have a COB provision, the group covering the person as a participant is primary.
- C) If a dependent child is covered under both parents' group plan and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. For purposes of determining the earlier birthday only the month and day are considered; the year of birth has no significance. If both parents have the same birthday, the plan which covered the parent longer will be primary. However, if the other group plan does not use the "birthday rule;" but instead uses a rule based on the gender of the parent and as a result the two plans do not agree on which is primary, then the father's group plan shall be primary.
- D) If a dependent child is covered under both parents' group plan, the parents are separated or divorced, there is no court decree which establishes financial responsibility for the child's coverage, the plan of the parent who has custody (the custodial parent) shall be primary. However, 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 will pay first, the step-parent's plan second and the non-custodial parent's plan third.
- E) If a court decree specifies which parent is to be responsible for the child's coverage and that parent's plan has actual knowledge of the decree, then that parent's plan will be primary.

- F) If a person is covered under one group as an active participant or as the dependent of an active participant and is also covered under another group as a retired participant or as the dependent of a retired participant, the group which covers that person as an active participant is primary. If the other group plan does not have this rule, and as a result the two plans do not agree on which is primary, then this rule will be ignored.
- G) If none of the above rules determine which group plan is primary, the group plan covering the person for the longer period of time is primary.

## **LIFE INSURANCE AND ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE**

### ***Who Provides Our Life Insurance Benefits?***

Aetna Life Insurance Company has been designated by the Trustees to provide group life insurance benefits for any participant who is eligible for coverage under the Welfare Fund. If you are an active covered participant and you die from any cause, your designated beneficiary will be paid \$50,000.

### ***Does Our Life Insurance Include Accelerated Death Benefits?***

Yes, while covered under the Welfare Fund for Life Insurance you become terminally ill, you may request that Aetna pay an Accelerated Death Benefit (herein called ADB). Upon Aetna's approval of any such request, they will pay you up to \$37,500 (75% of the life benefit of \$50,000).

The benefit will also allow the participant to apply for this benefit if diagnosed with amyotrophic lateral sclerosis (a/k/a Lou Gehrig's Disease); end stage heart, 6, liver and/or pancreatic organ failure wherein the person is not a transplant candidate; a medical condition requiring artificial life support, without which the person would die; or a permanent neurological deficit resulting from a cerebral vascular accident (eg., stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a Hospital or Skilled Nursing Facility. A terminal illness diagnosis requires the life expectancy must be no longer than 24 months. For the aforementioned named medical diagnoses, the life expectancy requirement does not apply.

The ADB program is very complicated. Contact the Fund Office for specific details regarding this benefit.

## ***Can I Continue Life Insurance If I Fail To Remain Covered Under The Group Plan?***

If your Welfare Fund coverage terminates, you may apply, without medical examination or other evidence of insurability, for an individual life insurance policy through Aetna Life Insurance Company. Your application for conversion and premium payment must be made within 31 days after the termination of your insurance. Contact the Fund Office for complete details.

Your group life insurance is payable if you die within the 31-day period following termination of insurance, whether or not you have applied for conversion to an individual policy.

## ***What Is Accidental Death Or Dismemberment Insurance?***

If, while you are insured, you are injured in a *non-employment related accident* and the accident is the sole cause of the injury, the injury is the sole cause of the covered loss and the covered loss occurs within one year of the date of accident, you or your beneficiary will receive the following benefits:

<b><i>Benefit</i></b>	<b><i>Payable for</i></b>
\$20,000	loss of life.
\$50,000	loss of both hands, both feet, or both eyes.
\$50,000	loss of both hearing and speech.
\$50,000	quadriplegia.
\$20,000	third degree burns covering 75% or more of the body.
\$25,000	loss of either hearing or speech.
\$25,000	loss of a hand, loss of a foot, or loss of an eye.
\$25,000	paraplegia.
\$25,000	hemiplegia.
\$10,000	third degree burns covering 50% to 74% of the body.
\$12,500	loss of the thumb and index finger of the same hand.
\$5,000	uniplegia.

## ***The Loss Must Result From And Occur Within One Year Of The Accident.***

Accidental dismemberment benefits are payable to the participant, but life insurance and accidental death benefits will be paid to your designated beneficiary.

Only one of the above amounts, the largest, will be paid on an Accidental Death or Dismemberment claim which results from one accident. No more than \$50,000 is payable for all losses resulting from the same accident. The benefit for Accidental Death is in addition to your basic life insurance benefit.

### ***Additional Accidental Death Benefits***

The following are additional benefits and will be payable if, while insured, a participant suffers a bodily injury by accident and if, within 365 days after accident, he or she suffers a loss of life solely as a direct result of the accident.

#### **A) Passenger Restraint and Airbag Benefit:**

If a covered loss of life of the participant occurs as a direct result of a motor vehicle accident and the insured is properly using a passenger restraint and (if the driver) is properly licensed, a benefit will be payable. If an airbag is activated as a result of the same accident, an additional benefit will be payable. Passenger restraint and airbag usage will require verification. The benefit provides for \$10,000 for use of a passenger restraint and an additional \$5,000 if an airbag is activated.

#### **B) Education Benefit for Dependent Child and/or Spouse:**

If a loss of life of the participant occurs as a direct result of an accident, an education benefit will be payable on behalf of each dependent child and/or a surviving spouse for a maximum of 4 years from the date of death, with verification of continued entitlement. The benefit provides for an annual maximum of \$1,000.

A dependent child means a child who is, your biological child, or your adopted child, or your stepchild, any other child you support that lives with you in a parent-child relationship, and, for the purpose of this benefit, is an unmarried, full-time student and is attending school, up to and including the last grade of high school, or is under the age of 23 and attending college or trade school on a regular basis at the time of your death, or enrolls in college or trade school within 365 days after the claim has been approved.

The Education Benefit will be payable to the dependent child if that child has attained the age of majority. Otherwise, the Education Benefit will be payable to the guardian of the estate of the minor, or to the Custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

**C) Child Care Benefit:**

If you suffer a loss of life solely and as a direct result of an accident, a Child Care Benefit may be payable with respect to any dependent child enrolled in a legally licensed child care center. The benefit, not to exceed \$600 per year, is payable for a maximum of 4 years from the date of death.

For the purposes of this benefit, a dependent child means a child who is under age 13 and is enrolled in a legally licensed child care center on the date of the accident or subsequently enrolled in a legally licensed child care center within 90 calendar days after the date the claim is approved and is either your biological child, or your adopted child, or your stepchild, or any other child you support who lives with you in a parent-child relationship.

The Child Care Benefit will be payable to the guardian of the estate of the minor, or to the Custodian under the Uniform Transfers to Minors Act, or an adult caretaker, when permitted under applicable state law.

**D) Repatriation of Remains Benefit:**

This Plan pays a Repatriation of Remains Benefit for the actual expenses incurred to prepare a person's body for transportation to a mortuary if, as a direct result of an accident for which a benefit is payable under this section, he or she suffers loss of life while outside a 200 mile radius from his or her principal place of residence. The maximum benefit payable is \$5,000.

**E) Coma Benefit:**

If a covered participant suffers a bodily injury caused by an accident and as a direct result becomes comatose, a monthly benefit of \$1,000 of the Principal Sum less any benefit amount paid or payable because of the same accident will be payable for 11 months after the person has been continually comatose for at least 30 consecutive days. After 12 months of continuous coma, the full Principal Sum less any benefit amount paid or payable because of the same accident is payable.

## ***EXCLUSIONS***

Accidental Death or Dismemberment insurance benefits will not be paid for any covered loss which in any way resulted from, or was caused or contributed to by, any of the following:

- ◆ a bodily or mental infirmity.
- ◆ a disease or bacterial infection.\*
- ◆ medical or surgical treatment.\*
- ◆ suicide or attempted suicide.
- ◆ an intentionally self-inflicted injury.

- ◆ a war or any act of war (declared or not declared).
- ◆ commission of or attempt to commit a felony.
- ◆ use of alcohol, intoxicants, or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol.
- ◆ air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo).

\* *These do not apply if the loss is caused by:*

- *An infection which results directly from the injury.*
- *Surgery needed because of the injury.*
- *Medical malpractice.*

The injury must not be one which is excluded by the terms of this section.

***It is essential that you keep your beneficiary information current. Contact the Fund Office if you wish to change or update your beneficiary information.***

***Failure to do so can delay or prevent payment of your group life and accidental death insurance benefits or result in payment which is not what you wished.***

## SUPPLEMENTAL DISABILITY BENEFITS

**Benefit Amount and Qualifications:** A Weekly Disability Benefit of \$150.00 (\$30 per work day) will be payable to you if, while eligible, you become disabled so as to be unable to work. This benefit will be paid for a period of continuous disability not to exceed 26 weeks from the onset of the specific illness or injury that resulted in the claim.

In order to be eligible to receive this benefit, you must submit proof that you are eligible and receiving either New York State Weekly Disability or Workers' Compensation Benefits or similar benefits under the laws of any State of the United States.

### **Limitations and Exclusions:**

- (1) No supplemental disability benefits will be payable for any period for which you are entitled or receiving **Unemployment Insurance Benefits, Vacation Pay or Retirement Income Benefits** under an industry Pension and Retirement Benefit Plan.
- (2) No benefits will be payable for any period of disability resulting from any injuries sustained:
  - (a) while engaged in any employment other than that of a Metal Tradesmen,
  - (b) while participating in the commission of a felony,
  - (c) while serving in the armed services of any country or International Authority.

**How to File for Benefits:** To file for benefits, you must notify the Fund Office to obtain the appropriate claim form. Complete this form and submit it together with a copy of your New York State Disability or Workers' Compensation check. Thereafter, during the period of disability, you will be required to furnish a copy of your weekly disability check as proof of your continued disability.

All claim forms, together with required proofs, must be filed with the Fund Office within 90 days from the date of disability. Failure to file a claim within the required time period shall result in a forfeiture of benefits for any period of disability exceeding the 90 days from the date of disability, unless the claimant can furnish satisfactory evidence showing that it was not reasonably possible to file within the required time period. Notwithstanding anything herein to the contrary, no benefits will be paid for a period of disability for which a claim form has not been filed within the 12-month period following the date of disability.

**Continuation of Eligibility:** During the period in which you qualify for the Supplemental Disability Benefits program, you and your eligible dependents will remain covered in the Welfare Fund.

**Assignment:** No assignment can be made of this benefit.



# CLAIM FILING PROCEDURES

## ***HOSPITAL***

### **Empire BlueCross Deluxe PPO**

Should you or any of your dependents require emergency care or admission to a participating hospital, you would present your Empire identification card and Medicare card (where appropriate) at the time of service. The hospital will bill Empire for benefits payment. No claim forms are required for hospital coverage since all hospital benefits, except for emergency care, *must be* pre-certified.

## ***MEDICAL BENEFITS***

### **Empire BlueCross Deluxe PPO**

There are no claim forms to file for medical benefits for services rendered by participating PPO providers. You simply identify yourself as a member of PPO by showing your identification card to the provider and make any required co payment. The providers are responsible for filing all claims for benefits directly with Empire HealthChoice, Inc.- Deluxe PPO.

## ***DENTAL BENEFITS***

### **MetLife Preferred Dentist Program**

All necessary forms for dental work can be obtained by calling MetLife at 1-800-942-0854. Claim forms can be downloaded from the MetLife web site ([www.metlife.com/dental](http://www.metlife.com/dental)). Access specific information about dental claims at <http://metlife.com/mybenefits>.

You must bring a claim form with you to your appointment. You must complete the employee portion of the claim and your dentist will complete the rest. Then, either you or your dentist can directly submit it to MetLife for processing. If your dentist uses his/her own computerized form, attach a copy to your MetLife claim form and send it to MetLife.

If you require treatment in excess of \$300, you and your dentist should submit a pre-treatment estimate outlining the treatment plan and related charges. This way, you will know what services MetLife will cover and at what payment level. Services that usually require a pre-treatment estimate include crowns, bridges, inlays, onlays and periodontics.

## ***PRESCRIPTION DRUG PROGRAM***

### **Medco Health Solutions**

No claim forms are required for prescriptions obtained through the mail service or card program. If you are required to purchase a prescription because of circumstances beyond your control, contact the Fund Office (212-465-8888) to obtain a Direct Reimbursement Claim form. Your reimbursement under this program will be significantly less than your purchase price of the prescription. After you and your pharmacist have completed the claim form, return it to the Fund Office for processing.

## ***VISION CARE BENEFITS***

There is a special claim form for these benefits. Should you or any of your qualifying dependents require an application, contact the Fund Office (212-465-8888) or please visit the website address: <http://www.steamfitters.com/metal-forms.asp>. After you have completed the application and followed its specific instructions, submit it to the Welfare Fund's Medical Benefits Program for processing. An itemized receipt for the services rendered or products purchased *must* accompany the application.

## ***LIFE INSURANCE***

A claimant must contact the Fund to obtain the required claim forms. The claim form must be completed and then returned to the Fund Office together with proof of death or disability within 90 days of the loss. Failure to file within the prescribed period may be grounds for denying the claim unless the claimant can show good cause for non-compliance within the prescribed time period.

## **HOW TO APPEAL DENIED CLAIMS**

Your request for a review of a denied claim should be made in writing and sent, within 60 days of the receipt of the denial, to:

THE METAL TRADES BRANCH LOCAL 638 WELFARE FUND  
5 PENN PLAZA  
NEW YORK, NEW YORK 10001-1887

You may examine plan records relating to your claim as well as submit comments on your claim in person or through a representative.

The Administrator will present your request for review to the appropriate provider of services, and/or the Trustees.

The provider or the Trustees will respond to your appeal within 60 days, unless special circumstances make it necessary for them to take an additional 60 days to review your request. You will be notified of the need for an additional 60 days before the end of the initial 60 day period.

If you feel that legal action concerning the Welfare Fund is necessary, legal process may be served upon the Administrator, or upon one or more of the Trustees at the addresses shown in the front of this booklet.

## **MISCELLANEOUS PROVISIONS**

### ***ASSIGNABILITY***

Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, and any attempt to alienate any amount, whether presently or hereafter payable shall be void, provided that benefits payable at any time may be used to make direct payments to health care providers upon written authorization of the participant. The Fund shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable through the Welfare Fund, or any part thereof.

### ***FILING OF INFORMATION***

Each eligible participant, qualifying dependent or other interested person shall file with the Welfare Fund such pertinent information as requested, including proof or continued proof of eligibility or dependency, and in such a manner and form as the Fund may specify or provide. Failure to file the requested information will result in the suspension of entitlement to any benefits hereunder until such time as said information is filed by the covered person or on behalf of the covered person.

### ***MISSTATEMENTS***

In the event of any misstatement of fact(s) affecting coverage and/or benefits under the Welfare Fund, the true facts will be used to determine the proper coverage and the participant or qualifying dependent will be liable to repay the Fund for any excess coverage or benefits provided on the basis of the misstatement.

### ***OVERPAYMENTS***

If a covered person has been paid benefits by the Welfare Fund that either should not have been paid or are in excess of the benefits that should have been paid, the Fund may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such covered person or other present or future amounts payable to such person. The Fund, in its sole discretion, may also recover such amount by any other legal method it shall determine. Each covered person hereby authorizes the deduction of such excess payment for such benefits or other present or future compensation payments.

### ***NO-FAULT BENEFITS***

If a person covered by this Plan has a claim, which involves a motor vehicle accident covered by the “no-fault” insurance law of any state, health care expenses must be reimbursed first by the no-fault insurance carrier. Only when the claimant has exhausted his or her health care benefits under the no-fault coverage will he or she be entitled to receive health care benefits under this Plan. If there are expenses for services that are covered under this Plan and which are not completely reimbursed by the no-fault carrier, such expenses may be reimbursed under this Plan, subject to the Plan’s applicable maximums and other provisions.

### ***PAYMENT TO OTHER THAN PARTICIPANT***

If it is determined that any person to whom benefits are payable is unable to care for personal affairs; is a minor; or has died, then any payment due the participant or his/her estate may be paid to the duly appointed legal representative, spouse, child, other relative or an institution maintaining or having custody of such person otherwise entitled to payment. In such a case, the Fund may, at its discretion, hold any such payments until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of the Fund Office.

### ***RIGHT OF INFORMATION***

For the purpose of determining the applicability of and implementing the terms of these benefits, the Welfare Fund may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any potential or current covered person who benefits from the Fund's coverage.

In so acting, the Welfare Fund shall be free from any liability that may arise with regard to such action. Any covered person claiming benefits shall furnish to the Welfare Fund information which may be necessary to implement this provision.

### ***NOTICE OF EXCLUSION***

As to those participants who elect to exclude themselves from a Worker Compensation and Employer Liability insurance policy, pursuant to a New York exclusion of Executive Officer, by executing a Worker’s Compensation policy endorsement, take note: said individuals will not be covered under this plan in the event that the injuries suffered by said excluded individual are work related and/or occurred on the job. Said work related and/or occupational injuries which, except for the election to exclude, would be covered under the employer’s Worker Compensation and Employer Liability policy have been specifically excepted by the policies of insurance herein described.

## **SUBROGATION**

The Welfare Fund has the right of subrogation. This subrogation right allows the Welfare Fund to pursue any claim which the covered person has against any third party or other insurer, whether or not the covered person chooses to pursue that claim. The Fund may make a claim directly against the third party or other insurer. In any event, the Fund has a lien on any amount recovered by the covered person whether or not designated as payment for medical expenses. The covered person automatically assigns to the Fund any rights against any third party or other insurer when this provision applies and must repay the benefits paid on his or her behalf out of the recovery made from the third party or other insurer. The Fund will have priority over any funds paid by the third party or other insurer to a covered person relative to the injury or illness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. The Welfare Fund's subrogation and recovery rights, as well as the rights assigned to it, are limited to the extent to which the Fund has made, or will make, payments for covered medical expenses as well as any costs and fees associated with the enforcement of its rights. The covered person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Fund's right of subrogation as a condition to having the Welfare Fund make payments. In addition, the covered person will do nothing to prejudice the right of the Fund to subrogate.

The subrogation process is being handled by Meridian Resource Company, LLC, in conjunction with their relationship with Empire BlueCross BlueShield. Should a potential subrogation case be identified, Meridian will send a letter and questionnaire to you to start the recovery process. If there is a lawsuit involved, the subrogation process will monitor the legal system to be sure that the Welfare Fund is fully repaid for any health care costs (included, but, not limited to hospital, medical, prescription, drug, dental costs, etc.,) it may have expended.

## YOUR RIGHTS UNDER ERISA

As a participant in The Metal Trades Branch Local 638 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- (i) Examine, without charge, at the Fund Office and at the Union Office, all Plan documents, including insurance or group health contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- (ii) Obtain copies of all documents and other plan information upon written request to the Fund Office. There may be a reasonable charge for the copies.
- (iii) Receive a summary of the plan's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit programs. The people who operate your programs, called "fiduciaries", have a duty to do so prudently and in the interest of you and all other participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or discriminate against you to prevent from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Fund review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Welfare Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Office.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the "fiduciaries" misuse the Fund'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 lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your benefit programs, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

## HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

The Metal Trades Branch Local 638 Welfare Fund (hereafter referred to as the “Fund”) is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Fund’s uses and disclosures of Protected Health Information (“PHI”);
- your privacy rights with respect to your PHI;
- the Fund’s duties with respect to your PHI;
- your right to file a complaint with the Fund and to the Secretary of the U.S. Department of Health and Human Services, and
- the person or office to contact for further information about the Fund’s privacy practices.

**The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Fund regardless of form (oral, written, electronic).**

### **Protected Health Information (“PHI”):**

In its normal course of business, the Fund receives, uses, and discloses personal health information about you and your eligible dependents, if any. The purpose of this notice is to inform you of how the Fund receives and protects your personal health information as well as under what circumstances the Fund uses and discloses that information. It should be noted that the Fund is required to protect your health information as well as provide you with a notice of the Fund’s privacy policies and procedures with regard to your personal health information. The Fund is required to abide by the terms of this notice. The Fund will continue to comply with the privacy policy in order to protect your personal health information. The Fund will not change these policies unless you are given notice of the change.



## **Uses and Disclosures:**

The Fund uses and discloses your PHI. Most of the time, those uses and disclosures of your PHI fall under a category of use and disclosure known as treatment, payment and health care operations (“TPO”). It is acceptable for the Fund to use and/or disclose your personal health information without your prior authorization provided it falls into one of the allowable reasons. The types of uses and disclosure that fall under this category are as follows:

1. the use of your PHI for health care operations, including paying benefits, coordinating claim payments, developing and supplying benefit eligibility, providing customer service, and assisting you with your inquiries or disputes,
2. the disclosure of your PHI by a provider to your health plan, or
3. the disclosure of your PHI by your health plan when processing a claim for payment, or
4. the use of your PHI by a direct treatment provider who is treating you.
5. the use of your PHI for business management and general administrative activities including training programs, quality assessment reviews and planning and development activities.

## **Other Uses and Disclosures:**

There are other uses and disclosures of your PHI that may occur without your authorization. Following is a description of these possibilities:

1. a disclosure pursuant to regulatory or legal proceeding;
2. a disclosure in response to a requirement of the government as authorized by law or law enforcement agencies made through a court order, subpoena, warrant, summons, or similar legal process;
3. to detect or prevent fraud;
4. to review the Fund’s utilization;
5. to conduct an audit of the claims and/or the claims operations;
6. to conduct an actuarial study;
7. for other uses relating to plan administration which are approved in writing by the Fund Administrator or Privacy Officer.

## **Authorization Regarding Uses and/or Disclosures of PHI:**

From time to time, there may arise the need for the Fund to seek your authorization before disclosing your PHI. Before a release of your PHI occurs, outside of the allowable reasons, the Funds will need to obtain your written authorization. You may give us written authorizations to disclose your PHI to any person or entity for any purpose. We cannot use or disclose your PHI except as described in this notice unless you give us written authorization. However, in the event of your incapacity or an emergency we will use our professional judgment to decide whether the disclosure would be in your best interest subject to any applicable laws or court orders.

## **Right to Revoke:**

You have a right to revoke this authorization at any time, in writing. There are two (2) exceptions as follows:

- a. If the information you authorized to be released has already been released.
- b. If your authorization was required as a condition of obtaining the coverage.

To revoke this authorization you may either complete a new authorization form stating someone else is authorized or that no one is authorized to use and/or disclose your PHI. Alternatively, you may submit a letter stating your intentions to revoke this authorization. In either case, the written revocation must be in an original document signed by you.

## **More Stringent Standard:**

When comparing this law to the State Law, if the State Law restricts the use and/or disclosure of PHI in an area not restricted under the Health Insurance Portability and Accountability Act of 1996 then the Fund must abide by State Law and restrict the disclosure of PHI in those cases. There are two (2) exceptions to this as follows:

1. If the PHI is required to be released by the Secretary of the Department of Health and Human Services in order to verify that the Funds are in compliance with the law and
2. the information may be released to the individual who is the subject of the PHI.

## **Your Rights:**

You have the right to request, in writing, to inspect and copy your personal health information. You also have the right to request that the Fund amend any information about you that may be incorrect. You may also request that the Fund restrict uses and/or disclosures of your PHI. The Fund has a right to deny your request for a restriction. You also have a right to receive communications of PHI by alternative means or at alternative locations. You have the right to receive certain disclosures of PHI provided they fall outside of the allowable reasons.

If you believe that your privacy rights have been violated, you may complain to the Fund Privacy Officer, c/o Steamfitters' Industry Fund Office, 5 Penn Plaza, 21<sup>st</sup> Floor, New York, NY 10001-1887. All complaints must be submitted in writing. In addition, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201.

**Whom to Contact at the Plan for More Information:**

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Fund by mail at: Metal Trades Branch Local 638 Welfare Fund, 5 Penn Plaza, 21<sup>st</sup> floor, New York, NY 10001-1887 or by telephone (212) 465-8888, Ext. 242.

**Additional Information:**

The Fund reserves the right to change any of the information or procedures regarding your Personal Health Information at any time. You will be notified of any such changes.

## **IMPORTANT ADDITIONAL INFORMATION**

The Welfare Fund is operated and controlled by a Joint Board of Trustees. The Trustees are responsible for interpreting the benefit programs, executing all contracts, amending or cancelling its provisions or benefits when they consider amendment or cancellation appropriate, and establishing whatever rules regarding the Fund's operation as they may deem necessary or appropriate. The Trustees intend to continue the Welfare Fund indefinitely, but reserve the right to terminate any or all of its coverages and/or benefits at any time for any reason.

The Trustees have appointed an administrator to be responsible for the day-to-day operation of the Welfare Fund. It is the administrator who arranges for the maintenance records, processing of claims for benefits and assistance in understanding your Fund. If you have any problems, the Fund Office will be glad to assist you.

Please understand that this is your Welfare Fund. You are encouraged to contact the Trustees or the Fund Office with any questions or comments you may have regarding benefits for you, your dependents and/or your beneficiaries.

# Empire PPO Guide

## The Metal Trades Branch Welfare Fund



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.

Blue Cross, Blue Shield, the Cross and Shield symbols and BlueCard are registered marks of the Blue Cross and Blue Shield Association.

AT&T Direct is a registered mark of AT&T. Weight Watchers is a registered mark of Weight Watchers International.

The Butterfly, 360° Health, HealthLine Nurse Access and HealthLine Recorded Topics are service marks of Empire HealthChoice Assurance, Inc.

# Welcome!

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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.

## 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](http://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	14
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	29
• HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	36

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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!

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## REGISTER NOW TO DO IT ON THE WEB!

Go to [www.empireblue.com](http://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"

*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](http://www.empireblue.com)
- Click on the Member tab and choose "Register"
- Follow the simple registration instructions

## ASSISTANCE IS A CLICK AWAY

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

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

## GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

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

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

Get health information for you and your family.

## YOUR PRIVACY IS PROTECTED

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

**Register today to experience hassle-free service!**  
**[www.empireblue.com](http://www.empireblue.com)**



# Your PPO Guide

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# Introduction

## Getting Answers Your Way

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

### ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit [www.empireblue.com](http://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

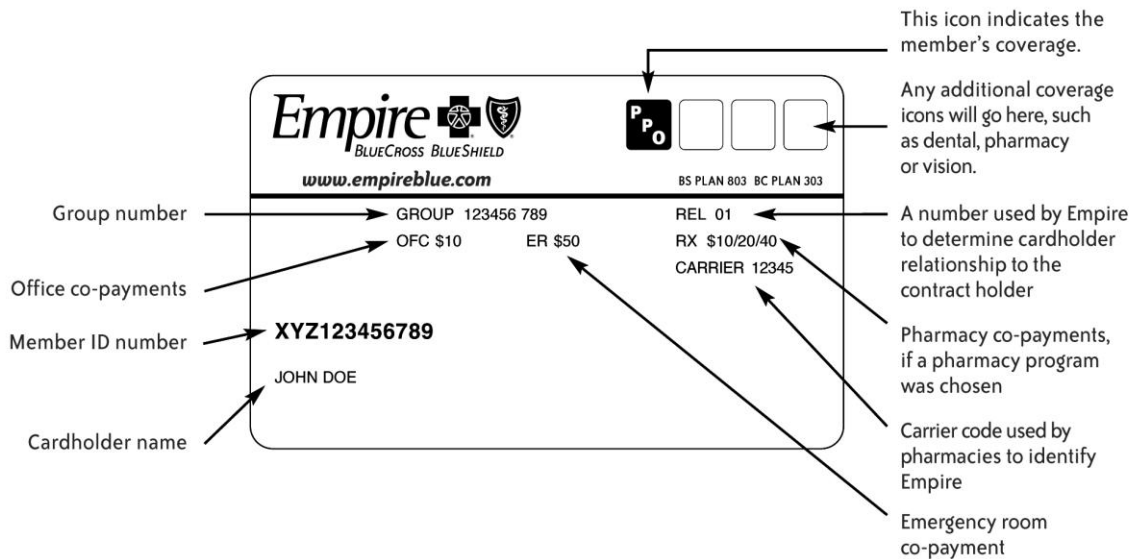
WHAT	WHY	WHERE
<b>MEMBER SERVICES</b>	For questions about your benefits, claims or membership	<b>1-800-553-9603</b> TDD for hearing impaired: <b>1-800-241-6895</b> 8:30 a.m. to 5:00 p.m. Monday – Friday
<b>ATT SERVICIOS PARA IDIOMAS EXTRANJEROS</b>	Si usted no habla inglés	<b>1-800-553-9603</b> Por favor 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
<b>BLUECARD® PPO PROGRAM</b>	Get network benefits while you are away from home  Locate a PPO provider outside Empire's network service area	<b>1-800-810-BLUE (2583)</b>  <a href="http://www.bcbs.com">www.bcbs.com</a> 24 hours a day, 7 days a week
<b>MEDICAL MANAGEMENT PROGRAM</b>	Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	<b>1-800-982-8089</b> 8:30 a.m. to 5:00 p.m. Monday – Friday
<b>HEALTHLINE<sup>SM</sup> NURSE ACCESS AND HEALTHLINE RECORDED TOPICS</b>	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	<b>1-877-TALK-2RN (825-5276)</b> 24 hours a day, 7 days a week
<b>BEHAVIORAL HEALTHCARE MANAGEMENT</b>	To locate a participating behavioral healthcare provider in your area  Precertification of mental health and alcohol/substance abuse care	<b>1-800-626-3643</b> NON-EMERGENCY CARE 8:30 a.m. to 5:00 p.m. Monday – Friday EMERGENCY CARE 24 hours a day, 7 days a week
<b>FRAUD HOTLINE</b>	Help prevent health insurance fraud	<b>1-800-I-C-FRAUD (423-7283)</b> 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.



To make it easier for you to use your new 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:** What do the icons in the upper right hand corner of the card mean?

**A:** The icons are illustrations of the plan(s) that you've enrolled in. The first icon shows that you're enrolled in the PPO. The other icons show which additional plans or programs you are enrolled in – pharmacy, dental or vision. It's easy to see what coverage you have!

**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](http://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

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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](http://www.empireblue.com).

### USE YOUR PPO TO YOUR BEST ADVANTAGE

Your health is valuable. Knowing how to use your PPO to your best advantage will help ensure that you receive high quality healthcare – with maximum benefits. Here are three ways to get the most from your coverage.

- **BE SURE YOU KNOW WHAT’S COVERED BY THE PLAN.** That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the plan applies to certain types of care.
- **PLEASE REMEMBER TO PRECERTIFY** hospital, ambulatory surgery (for medically necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. You’ll recognize these services when you see the telephone icon sign. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care – for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.
- **ASK QUESTIONS** about your healthcare options and coverage. To find answers, you can:
  - Read this Guide.
  - Call Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply.

Call HealthLine<sup>SM</sup> Nurse Access and Recorded Topics -- available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.

Talk to your provider about your care, learn about your benefits and your options, and ask questions. Empire is here to work with you and your provider to see that you get the best benefits while receiving the quality healthcare you need.

### CHOOSING IN-NETWORK OR OUT-OF-NETWORK SERVICES

In-network services are healthcare services provided by a doctor, hospital or healthcare facility that has been selected by Empire or another Blue Cross and/or Blue Shield plan to provide care to our members. 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<sup>®</sup> 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 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)
  - You will usually have to pay the provider when you receive care
  - You will need to file a claim to be reimbursed by Empire

Here's an example of how costs compare for in-network and out-of-network care.

	IN-NETWORK	OUT-Of-NETWORK
PROVIDER'S CHARGE	\$500	\$500
ALLOWED AMOUNT	\$400	\$400
PLAN PAYS PROVIDER	\$395	\$320 (80% of allowed amount)
YOU PAY PROVIDER	\$5 co-payment	\$180 (20% of allowed amount, plus the \$100 above the allowed amount. Assumes you have satisfied your deductible)

The following chart shows your specific plan information.  
See the Details and Definitions section for explanations of terms in the chart.

	IN-NETWORK	OUT-Of-NETWORK
ANNUAL DEDUCTIBLE*	\$0	\$300/Individual \$750/Family
CO-PAYMENT (for office visits and certain covered services)	\$5 per visit	N/A
CO-PAYMENT (for hospital inpatient admissions)	\$0	N/A
CO-PAYMENT (for emergency room)	\$35 per visit (waived if admitted to hospital within 24 hours)	\$35 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	N/A	You pay 20% of allowed amount. Plan pays 80% of allowed amount (50% for behavioral healthcare services).
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	N/A	\$1,000/Individual \$2,500/Family
LIFETIME MAXIMUM	Unlimited	\$1 million per person

## 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](http://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 1-800-553-9603.

\* If you had group coverage under a major medical or extended medical plan either with Empire or another carrier 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.

## YOUR PPO BENEFITS OUT-OF-AREA<sup>†</sup>

When you live or travel outside of Empire's operating area, Empire's PPO provides benefits through the following programs.

### **BlueCard<sup>®</sup> PPO Program**

Nationwide, Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other healthcare providers. By presenting your Empire I.D. card to a provider participating in the BlueCard PPO Program, you receive the same benefits as you would receive from an Empire PPO network provider. The suitcase logo on your I.D. card indicates that you are a member of the BlueCard PPO Program. Call 1-800-810-BLUE (2583) or visit [www.bcbs.com](http://www.bcbs.com) to locate participating providers.

### **BlueCard<sup>®</sup> Worldwide**

Need emergency services when traveling outside the United States? The BlueCard Worldwide program provides coverage through an international network of hospitals, doctors and other 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.

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<sup>†</sup> See the Details and Definitions section for more information on the BlueCard and BlueCard Worldwide programs.

# 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. See the Coverage section for more details.




When you see the telephone icon, you'll know that you or your doctor will need to precertify these services with Empire's Medical Management Program. In most cases, it is your responsibility to call. In some cases the provider or supplier of services needs to call. See the Health Management section for details.

HOME, OFFICE/OUTPATIENT CARE	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
HOME/OFFICE VISITS	\$5 co-payment per visit	Deductible and 20% coinsurance
SPECIALIST VISITS	\$5 co-payment per visit	Deductible and 20% coinsurance
CHIROPRACTIC CARE*	\$5 co-payment per visit	Deductible and 20% coinsurance
SECOND OR THIRD SURGICAL OPINION** ☎	\$5 co-payment per visit	Deductible and 20% coinsurance
DIABETES EDUCATION AND MANAGEMENT	\$5 co-payment per visit	Deductible and 20% coinsurance
ALLERGY TESTING and TREATMENT	\$5 co-payment per visit (co-payment waived for treatment)	Deductible and 20% coinsurance
DIAGNOSTIC PROCEDURES		
• X-rays and other imaging	\$0	
• Radium and Radionuclide therapy	\$0	
• MRIs/MRAs*** ☎	\$0	Deductible and 20% coinsurance
• Nuclear cardiology services*** ☎	\$0	
• PET/CAT scans*** ☎	\$0	
• Laboratory tests	\$0	
SURGERY ☎	\$0	Deductible and 20% coinsurance
PRE-SURGICAL TESTING	\$0	Deductible and 20% coinsurance
ANESTHESIA	\$0	Deductible and 20% coinsurance
CHEMOTHERAPY, RADIATION	\$0	Deductible and 20% coinsurance
KIDNEY DIALYSIS	\$0	Deductible and 20% coinsurance





\* It is the provider's responsibility to call Empire for precertification of all in-network chiropractic care after the fifth visit. Precertification is not necessary for out-of-network services.

\*\* The co-payment is waived if the surgical opinion is arranged through Empire's Medical Management Program.

\*\*\* It is the provider's responsibility to call Empire for precertification of all in-network PET/ CAT scans, MRIs/ MRAs and Nuclear Cardiology services. It is your responsibility to call Empire for precertification of out-of-network MRI/ MRA services. Precertification is not necessary for out-of-network PET/ CAT scans and Nuclear Cardiology services. Please refer to the Medical Management section for details.










	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	IN-NETWORK	OUT-OF-NETWORK
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	\$5 co-payment per visit	Deductible and 20% coinsurance
CARDIAC REHABILITATION 	\$5 co-payment per outpatient visit	Deductible and 20% coinsurance
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
ANNUAL PHYSICAL EXAM <ul style="list-style-type: none"> <li>One per calendar year</li> </ul>	\$5 co-payment per visit	Not covered
DIAGNOSTIC SCREENING TESTS <ul style="list-style-type: none"> <li>Cholesterol: 1 every 2 years</li> <li>Diabetes (if pregnant or considering pregnancy)</li> <li>Colorectal cancer <ul style="list-style-type: none"> <li>Fecal occult blood test if age 40 or over: 1 per year</li> <li>Sigmoidoscopy if age 40 or over: 1 every 2 years</li> </ul> </li> <li>Routine Prostate Specific Antigen (PSA) in asymptomatic males <ul style="list-style-type: none"> <li>Over age 50-: 1 every year</li> <li>Between ages 40-49 if risk factors exist: 1 per year</li> <li>If prior history of prostate cancer, PSA at any age</li> </ul> </li> <li>Diagnostic PSA: 1 per year</li> </ul>	\$0 \$0 \$0 \$0 \$0	Deductible and 20% coinsurance
WELL-WOMAN CARE <ul style="list-style-type: none"> <li>Office visits</li> <li>Pap smears</li> <li>Bone Density testing and treatment</li> <li>Mammogram (based on age and medical history) <ul style="list-style-type: none"> <li>Ages 35 through 39 – 1 baseline</li> <li>Age 40 and older – 1 per year</li> </ul> </li> </ul>	\$5 co-payment per visit \$0 \$0 \$0	Deductible and 20% coinsurance
WELL-CHILD CARE <ul style="list-style-type: none"> <li>Office visits and associated lab services provided within 5 days of office visit <ul style="list-style-type: none"> <li>Newborn: 1 in-hospital exam at birth</li> <li>Birth to age 1: 7 visits</li> <li>Ages 1 through 2: 3 visits</li> <li>Ages 3 through 6: 4 visits</li> <li>Ages 7 up to 19th birthday: annual visits</li> </ul> </li> <li>Immunizations</li> </ul>	\$0 \$0	Deductible and 20% coinsurance
EMERGENCY CARE	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY ROOM 	\$35 per visit co-payment (waived if admitted to the same hospital within 24 hours)	
PHYSICIAN'S OFFICE	\$5 co-payment per visit	Deductible and 20% coinsurance
AIR AMBULANCE 	\$0	You pay the difference between the allowed amount and the total charge.
AMBULANCE <ul style="list-style-type: none"> <li>Local professional ground ambulance to nearest hospital</li> </ul>	\$0 up to the allowed amount; you pay the difference between the allowed amount and the total charge.	



	YOU PAY	
MATERNITY CARE AND INFERTILITY TREATMENT	IN-NETWORK	OUT-OF-NETWORK
PRENATAL AND POSTNATAL CARE (In doctor's office) 	\$0	Deductible and 20% coinsurance
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	\$0	Deductible and 20% coinsurance
ROUTINE NEWBORN NURSERY CARE (In hospital)	\$0	Deductible and 20% coinsurance
OBSTETRICAL CARE (In hospital) 	\$0	Deductible and 20% coinsurance
INFERTILITY TREATMENT	\$0	Deductible and 20% coinsurance
OBSTETRICAL CARE (In birthing center) 	\$0	Not covered
HOSPITAL SERVICES* 	IN-NETWORK	OUT-OF-NETWORK
SEMI-PRIVATE ROOM AND BOARD	\$0	Deductible and 20% coinsurance
ANESTHESIA AND OXYGEN	\$0	Deductible and 20% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	\$0	Deductible and 20% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	\$0	Deductible and 20% coinsurance
DRUGS AND DRESSINGS	\$0	Deductible and 20% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	\$0	Deductible and 20% coinsurance
INTENSIVE CARE	\$0	Deductible and 20% coinsurance
KIDNEY DIALYSIS	\$0	Deductible and 20% coinsurance
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	\$0	Deductible and 20% coinsurance
SURGERY (Inpatient and Outpatient) **	\$0	Deductible and 20% coinsurance

\* Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation. Inpatient admissions and certain outpatient hospital surgeries need to be precertified.






\*\* 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
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor) 	\$0	Not covered
ORTHOTICS 	\$0	Not covered
PROSTHETICS (i.e. artificial arms, legs, eyes, ears) 	\$0	Not covered
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	\$0	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)*	\$0	Deductible and 20% coinsurance
SKILLED NURSING AND HOSPICE CARE	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY  Up to 120 days per calendar year	\$0	Not covered
HOSPICE  Up to 210 days per lifetime	\$0	Not covered
HOME HEALTH CARE	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE  Up to 200 visits per calendar year (a visit equals 4 hours of care)	\$0	20% coinsurance only. No deductible
HOME INFUSION THERAPY 	\$0	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	IN-NETWORK	OUT-OF-NETWORK
PHYSICAL THERAPY AND REHABILITATION  <ul style="list-style-type: none"> <li>Up to 30 days of inpatient service per calendar year **</li> <li>Up to 60 visits combined in home, office or outpatient facility per calendar year</li> </ul>	\$0  \$5 co-payment per visit	Deductible and 20% coinsurance  Not covered
OCCUPATIONAL, SPEECH, VISION THERAPY <sup>1</sup>  <ul style="list-style-type: none"> <li>Up to 30 visits per person combined in home, office or outpatient facility per calendar year</li> </ul>	\$5 co-payment per visit	Not covered

\* \$2,500 combined in- and out-of-network limit for modified solid food products in any continuous 12-month period.

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

<sup>1</sup> Vision therapy does not require precertification.

	YOU PAY	
MENTAL HEALTH CARE 	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT *  • Up to 60 visits per calendar year <sup>1</sup>	\$25 co-payment per visit	Deductible and 50% coinsurance
INPATIENT  • Up to 30 days per calendar year • Up to 30 visits from mental health care professionals per calendar year	\$0  \$0	Not covered  Not covered
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT  • Up to 60 visits per calendar year, including up to 20 visits for family counseling <sup>1</sup>	\$0	Deductible and 20% coinsurance
INPATIENT  • Up to 7 days detoxification per calendar year • Up to 30 days rehabilitation per calendar year	\$0 \$0	Not covered Not covered

\* Out-of-network outpatient visits do not require precertification.

<sup>1</sup> Treatment maximums are combined for in-network and out-of-network care.

# Coverage

## Doctor's Services

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

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

### Tips For Visiting Your Doctor

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

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

### What's Covered

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

- Consultation requested by the attending physician for advice on an illness or injury
- Diabetes supplies prescribed by an authorized provider:
  - Blood glucose monitors, including monitors for the legally blind
  - Testing strips
  - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
  - Oral agents for controlling blood sugar
  - Other equipment and supplies required by the New York State Health Department
  - Data management systems
- Diabetes self-management education and diet information, including:
  - Education by a physician, certified nurse practitioner or member of their staff:
    - At the time of diagnosis
    - When the patient's condition changes significantly
    - When medically necessary
  - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
  - Home visits for education when medically necessary
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Medically necessary hearing examinations

- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Chiropractic care (your provider must call Empire’s Medical Management Program to precertify services after the fifth visit)

**What’s Not Covered**

The following medical services are not covered:

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
- Orthotics for treatment of routine foot care
- Routine hearing exams
- Routine vision care
- Hearing aids and the examination for their fitting
- Services such as laboratory, X-ray and imaging, and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship
- Services given by an unlicensed provider or performed outside the scope of the provider’s license

## Emergency Care

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**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 one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

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

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 HealthLine 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.

## **Tips For Getting Emergency Care**

- If time permits, speak to your physician to direct you to the best place for treatment
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard® PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room, and if you are admitted, notify Empire's Medical Management Program within 48 hours of admission. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard® Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

## **What's Not Covered**

These emergency services are not covered:

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

## **Air Ambulance**

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

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

If Empire determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by land ambulance to the nearest acute care hospital, Empire will only pay up to the amount that would be paid for land ambulance to that hospital.

Benefits must be authorized by Empire's Medical Management program before services are rendered, or within forty eight (48) hours after a Covered Person is admitted to or treated at the hospital, or as soon as reasonably possible. Failure to obtain authorization from Empire within the required time will result in a penalty of 50% of benefits otherwise available.

Remember to call Empire's Medical Management Program at 1-800-982-8089 for prior authorization or within 48 hours after services to receive benefits for air ambulance and to avoid the 50% penalty. Remember to call Empire's Medical Management Program at 1-800-982-8089 to receive benefits for air ambulance.

# Maternity Care and Infertility Treatment

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## IF YOU ARE HAVING A BABY

There are no out-of-pocket expenses after the initial office visit co-payment for maternity and newborn care when you use in-network providers. That means you do not need to continue to pay a co-payment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the hospital or birthing center, as well as routine newborn nursery care are all covered 100% in-network.

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

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

Whether services are provided in-network or out-of-network, call Empire's Medical Management Program at 1-800-982-8089 within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

Your baby is automatically covered under the plan for the first 30 days if you have family coverage. However, you will need to add the baby's name as a covered dependent. If you do not have family coverage, call your employer within 30 days to add your newborn as a dependent.

## MATERNITY CARE PROGRAM

Empire understands that having a baby is an important and exciting time in your life, so we developed the Maternity Care 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 Maternity Care 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 Maternity Care Program. Call 1-800-845-4742 and listen for the prompt that says "precertify." You will be transferred to the Maternity Care Program.

*Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.*

### What's Covered

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

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this timeframe (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician
- Parent education, and assistance and training in breast or bottle feeding, if available
- Circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother. Call Empire's Medical Management Program to precertify the hospital stay.
- Semi-private room

### What's Not Covered

These maternity care services are not covered:

- Days in hospital that are not medically necessary (beyond the 48-hour/96-hour limits)
- Services that are not medically necessary
- Private room
- Out-of-network birthing center facilities
- Private duty nursing

#### REMEMBER

**Use a network obstetrician/gynecologist to receive the lowest cost maternity care.**

### ***Infertility Treatment***

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations. Following are covered services and limitations:

- 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 services in relation to diagnostic tests and procedures necessary
  - to determine infertility, or
  - in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered 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.

Services must be medically necessary and must be received from eligible providers as determined by Empire in accordance with applicable regulations of the New York State Insurance Department. In general, an eligible provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

### ***What's Not Covered***

We will not cover 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
- Medical or surgical services or procedures that are experimental
- Services to diagnose or treat infertility if we determine, in our sole judgment, that the service was not medically necessary.

For members covered under this group plan, the new contract a member may convert to after termination of coverage may not contain these infertility benefits.



# Hospital Services

## IF YOU VISIT THE HOSPITAL

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

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

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

Remember to call Empire's Medical Management Program at 1-800-982-8089 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or surgical procedure, call Medical Management within 48 hours or as soon as reasonably possible. Otherwise your benefits may be reduced by 50% up to \$2,500 for each hospital admission or surgery that is not precertified. Benefit reductions will also apply to all care related to the admission, including physician services.

The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the Health Management section for additional information.

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

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

### Tips For Getting Hospital Care

- If your doctor prescribes pre-surgical testing (unlimited visits), have your tests done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room
- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

### Inpatient And Outpatient Hospital Care

#### **What's Covered**

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

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration)
- Anesthesiologist, including one consultation before surgery and services during and after surgery
- Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, PET/CAT scans and nuclear cardiology services, when pre-approved by Empire's Medical Management Program (your provider must call to precertify these services). You must call to precertify out-of-network MRIs/MRAs.

### Inpatient Hospital Care

#### **What's Covered**

Following are additional covered services for inpatient care:

- Semi-private room and board when
  - The patient is under the care of a physician,                  – A hospital stay is medically necessary.
- Coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified
- Operating and recovery rooms

- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital
- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery
  - Surgery on the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

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

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

## **Outpatient Hospital Care**

### ***What's Covered***

Following are additional covered services for same-day care:

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

## **Inpatient Hospital Care**

### ***What's Not Covered***

These inpatient services are not covered:

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

## **Outpatient Hospital Care**

### ***What's Not Covered***

These outpatient services are not covered:

- Same-day surgery not precertified as medically necessary by Empire's Medical Management Program
- Routine medical care including but not limited to:
  - Inoculation or vaccination
  - Drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow.

# Durable Medical Equipment and Supplies

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## IF YOU NEED EQUIPMENT OR MEDICAL SUPPLIES

Your plan covers the cost of medically necessary prosthetics, orthotics and durable medical equipment from network suppliers only. In-network benefits and plan maximums are shown in Your *Benefits at a Glance* section. Out-of-network benefits are not available.

The network supplier must precertify the rental or purchase by calling Empire's Medical Management Program at 1-800-982-8089. When using a supplier outside Empire's operating area through the BlueCard PPO Program, you are responsible for precertifying services. An Empire network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-553-9603.

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

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available both in- and out-of-network. If you have prescription drug coverage with Empire Pharmacy Management<sup>SM</sup>, you may order these formulas or supplements through the Empire Pharmacy Management Program.

### Tip For Obtaining Special Medical Supplies

For prosthetics, orthotics and durable medical equipment, be sure the network vendor knows the number to call for Medical Management precertification.

### What's Covered

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

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

### What's Not Covered

The following equipment is not covered

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

# Skilled Nursing and Hospice Care

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## IF YOU NEED SKILLED NURSING OR HOSPICE CARE

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

In order to receive maximum benefits, please call 1-800-982-8089 to precertify skilled nursing and hospice care with Empire's Medical Management Program.

### Skilled Nursing Care

#### What's Covered

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

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

#### What's Not Covered

The following skilled nursing care services are not covered:

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

### Hospice Care

Empire covers up to 210 days of hospice care once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

#### What's Covered

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

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

## Tips for Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility, ask your doctor or caseworker to see the Health Facilities directory.
- Empire's Medical Management Program will help direct you to a skilled nursing facility that provides the appropriate care. When selecting from among multiple facilities, you may want to consider:
  - Is the facility's location convenient to friends, relatives and doctors?
  - What size facility is most suitable? A large facility may have more activities; a smaller one may be more personal.
  - Are visiting hours convenient for friends and relatives?
  - Who directs your care? Does your doctor have privileges at the facility?
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

# Home Health Care

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## IF YOU NEED HOME HEALTH CARE

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

Remember, in order to receive maximum benefits, you need to precertify home health care through Empire's Medical Management Program. If you use a home health care agency in the Empire network, the agency is responsible for calling Medical Management. If you use a home health care agency in the BlueCard PPO network or out-of-network, *you* need to call Medical Management. (The agency can call for you; however, you need to ensure that they call.)

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network. If you use an Empire network home infusion supplier, the supplier must call Medical Management for precertification. While a BlueCard PPO supplier can call to precertify your treatment, you need to ensure that they call.

An Empire network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-553-9603.

### **What's Covered**

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

- Up to 200 precertified home health care visits per year, combined in- and out-of-network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Part-time home health aide services (skilled nursing care)
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a doctor
  - Laboratory tests

### **What's Not Covered**

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care
- Out-of-network home infusion therapy

# Physical, Occupational, Speech or Vision Therapy

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## IF YOU NEED THERAPY

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

Please call Empire's Medical Management Program at 1-800-982-8089 to precertify all physical, occupational, and speech therapy. This will ensure that you receive maximum benefits.

### Tip for Receiving Therapy

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

### What's Covered

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

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an inpatient or outpatient basis up to the plan maximums if:
  - Prescribed by a physician,
  - Designed to improve or restore physical functioning within a reasonable period of time, and
  - Approved by Empire's Medical Management Program.

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

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

### What's Not Covered

The following therapy services are not covered:

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

# Behavioral Healthcare

## IF YOU NEED BEHAVIORAL HEALTHCARE

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

Please note that, with the exception of outpatient alcohol and substance abuse treatment, the coinsurance that you pay for out-of-network behavioral healthcare services will not count toward reaching your annual out-of-pocket maximum.

To help ensure that you receive appropriate care, you need to precertify all behavioral healthcare services in advance, except for outpatient mental health care on an out-of-network basis. When you call the Behavioral Healthcare Management Program at 1-800-626-3643 to precertify in-network services, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

If you do not call to precertify behavioral healthcare, or if you call but do not follow their recommended treatment plan, covered benefits may be denied or reduced as follows:

- 50% up to \$2,500 per inpatient admission for mental health or alcohol/substance abuse detoxification
- 50% for each outpatient mental health visit to an in-network provider
- 50% for each outpatient alcohol and substance abuse facility or provider visit
- 50% for each professional mental health care visit made during an inpatient stay

### REMEMBER



**When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Healthcare Management Program at 1-800-626-3643 within 48 hours or as soon as is reasonably possible.**

**If you want to know if a provider or facility is covered in-network, call the Behavioral Healthcare Management Program.**

**If you do not agree with a certification decision made by the Behavioral Healthcare Management Program, you can file an appeal. For more information see "Appeals and Grievances" in the Details and Definitions section.**

## Mental Health Care

### What's Covered

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

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management.
- Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy.
- Treatment in a comprehensive care center for eating disorders.

### What's Not Covered

The following mental health care services are not covered:

- Care that is not medically necessary
- Out-of-network inpatient mental health care

## **Treatment for Alcohol or Substance Abuse**

### ***What's Covered***

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

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive one counseling visit per day.
- Visits for family counseling are deducted from the 60 visits available for outpatient treatment.
- Out-of-network outpatient treatment at a facility that:
  - Has New York State certification from the Office of Alcoholism and Substance Abuse Services
  - Is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient's diagnosis.

### ***What's Not Covered***

The following alcohol and substance abuse treatment services are not covered

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



# Exclusions and Limitations

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## EXCLUSIONS

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

### Dental Services

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

However, your plan does cover:

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

### Experimental/Investigational Treatments

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

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

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

However, your plan will cover an experimental or investigational treatment approved by an External Appeal agent certified by the state. *Refer to the Complaints, Appeals and Grievances Section.*

### Government Services

- Services covered under government programs, except Medicaid or where otherwise noted
- Government hospital services, except:
  - Specific services covered in a special agreement between Empire and a government hospital
  - United States Veterans’ Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.

### Home Care

- Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency.

### **Inappropriate Billing**

- Services usually given without charge, even if charges are billed
- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified

### **Medically Unnecessary Services**

- Services, treatment or supplies not medically necessary in Empire's judgment. See Definitions section for more information.

### **Miscellaneous**

- Surgery and/or treatment for gender change

### **Prescription Drugs**

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

### **Sterilization/Reproductive Technologies**

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

### **Travel**

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

### **Vision Care**

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

### **War**

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

### **Workers' Compensation**

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

## **LIMITATION AS INDEPENDENT CONTRACTOR**

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

# Health Management

## HELPING YOU MANAGE YOUR HEALTH

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 three important services: Medical Management, Case Management and HealthLine<sup>SM</sup> Nurse Access.

### Empire's Medical Management Program

Empire's Medical Management Program is a service that precertifies hospital admissions and certain treatments and procedures to ensure that you receive high quality care for the right length of time, in the right setting, with maximum coverage.

When you call Empire's Medical Management Program, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- Learn more about your healthcare options
- Avoid unnecessary hospitalization and the associated risks, whenever possible
- Choose the most appropriate healthcare setting or service (e.g., hospital or same-day surgery unit)
- Arrange for any required (and covered) discharge services

To help ensure that you receive quality care, Empire's Medical Management Program works with you and your provider to:

- Review planned and emergency hospital admissions
- Review ongoing hospitalization
- Coordinate purchase and replacement of durable medical equipment, prosthetics and orthotics
- Review inpatient and same-day surgery
- Review high risk pregnancies
- Perform individual case management
- Review care in a hospice or skilled nursing facility
- Review home health care and home infusion therapy
- Coordinate discharge planning

In most situations, you or someone acting on your behalf needs to call the Medical Management Program to precertify hospital admissions and certain services. In other cases, the vendor or provider of services needs to call. This will ensure you receive maximum benefits.

The following chart shows which healthcare services must be precertified with Empire's Medical Management Program before you receive them.

CALL TO PRECERTIFY ...	HOW COVERED	WHO CALLS TO PRECERTIFY
<b>ALL HOSPITAL ADMISSIONS</b> <ul style="list-style-type: none"> <li>At least two weeks prior to any planned surgery or hospital admission</li> <li>Within 48 hours of an emergency hospital admission, or as soon as reasonably possible</li> <li>For illness or injury to newborns</li> </ul>	In-network and Out-of-network	YOU
<b>PREGNANCY</b> <ul style="list-style-type: none"> <li>Within the first three months of a pregnancy</li> </ul>	In-network and Out-of-network	YOU
<b>BEFORE YOU RECEIVE</b> <ul style="list-style-type: none"> <li>Inpatient physical therapy</li> <li>Same-day surgery for medically necessary cosmetic/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures</li> <li>Cardiac rehabilitation</li> </ul>	In-network and Out-of-network	YOU
<b>BEFORE YOU RECEIVE</b> <ul style="list-style-type: none"> <li>Hospice care</li> <li>Occupational or speech therapy</li> <li>Outpatient physical therapy</li> <li>Skilled nursing facility care</li> <li>Air ambulance service</li> </ul>	In-network only	YOU
<b>BEFORE YOU RECEIVE</b> <ul style="list-style-type: none"> <li>Home health care services</li> </ul>	Empire network	NETWORK SUPPLIER
	Out-of-network or BlueCard PPO network	YOU
<b>BEFORE YOU</b> <ul style="list-style-type: none"> <li>Receive home infusion therapy</li> <li>Rent, purchase or replace prosthetics, orthotics or durable medical equipment</li> </ul>	Empire network	NETWORK SUPPLIER
	BlueCard PPO network	YOU
<b>BEFORE YOU RECEIVE</b> <ul style="list-style-type: none"> <li>Chiropractic care*</li> <li>MRIs/MRAs**</li> <li>Nuclear cardiology services **</li> <li>PET/CAT scans**</li> </ul>	Empire network	PROVIDER
	BlueCard PPO network	NO PRECERTIFICATION REQUIRED

**REMEMBER** When you call the Medical Management Program to precertify services, you receive maximum benefits and helpful advice about your options

\* It is the provider's responsibility to call Empire for precertification of all in-network chiropractic care after the fifth visit. Precertification is not necessary for out-of-network services.

\*\* It is the provider's responsibility to call Empire for precertification of all in-network PET/ CAT scans, MRIs/ MRAs and Nuclear Cardiology services. It is your responsibility to call Empire for precertification of out-of-network MRI/ MRA services. Penalties will apply if precertification is not obtained. Precertification is not necessary for out-of-network PET/ CAT scans and Nuclear Cardiology services..

## IF SERVICES ARE NOT PRECERTIFIED

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to \$2,500 for each admission, treatment or procedure. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not medically necessary, no benefits will be paid.

### Tips for Precertifying Services with Medical Management

- Have the following information about the patient ready when you call:
  - Name, birth date and sex
  - Address and telephone number
  - Empire I.D. card number
  - Name and address of the hospital/facility
  - Name and telephone number of the admitting doctor
  - Reason for admission and nature of the services to be performed
- When the vendor or provider is required to call Empire’s Medical Management Program for precertification, be sure they know about the precertification requirement and that they have the Medical Management telephone number.

### Initial Decisions

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

- *Precertification Requests.* Precertification means that you must contact Empire’s Medical Management Program for approval before you receive certain health care services. We will review all requests for precertification within three (3) business days of receipt of the 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 three (3) business days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within three (3) business days of our receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.
- *Urgent Precertification Requests.* If the need for the service is urgent, we will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and we require further information to make our decision we will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. We will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- *Concurrent Requests.* Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. We will complete all concurrent reviews of services within 24 hours of our receipt of the request.
- *Retrospective Requests.* Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within 15 calendar days of our receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.

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.

# New Medical Technology

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## REQUESTING COVERAGE

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

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

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

# Case Management

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## IF YOU NEED ADDITIONAL SUPPORT FOR SERIOUS ILLNESS

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

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

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

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

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

# Healthy Living Programs

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## PREVENTIVE CARE

Preventive care is an important and valuable part of your healthcare. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why Empire provides many preventive care services for free or only a small co-payment when you use network providers.

For more information on staying healthy, be sure to check the My Health section of [www.empireblue.com](http://www.empireblue.com). There you'll find the latest information on hundreds of topics ranging from nutrition to stress management to children's immunization guidelines.

### Tips For Using Preventive Care

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

### What's Covered

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

- Well-woman care visits to a gynecologist/obstetrician
- 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 for individuals meeting the criteria of those 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.
- 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. The number of visits covered per year depends on your child's age.
- Well-child care immunizations as listed:
  - 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

### What's Not Covered

These preventive care services are not covered:

- Screening tests done at your place of work at no cost to you
- Free screening services offered by a government health department
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests

# 360° Health<sup>SM</sup> – Empire’s Health Services Programs

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## EMPIRE’S HEALTH SERVICES PROGRAM, 360° HEALTH<sup>SM</sup>, 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. 360° 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 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:

*HealthLine<sup>SM</sup> Nurse Access and Recorded Topics* – 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 more than 1,100 topics — from colds and sore throats to diabetes and cancer. Please refer to the back of this booklet for a list of recorded topics.

**HealthLine 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 HealthLine:

- 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](http://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<sup>TM</sup> (ASH Networks) — all without a doctor’s referral. Search ASH Network’s online directory at [www.healthyroads.com](http://www.healthyroads.com) and show your member ID at your office visit to qualify 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 visiting [www.healthyroads.com](http://www.healthyroads.com) 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 in the International Fitness Club Network (IFCN). You can even get discounts on home fitness equipment. To find a club near you and printout savings certificates, visit [www.ifcn.org](http://www.ifcn.org) or call 1-800-866-8466.

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

*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](http://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](http://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](http://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 to understand:

- Who is eligible for coverage under your plan
- How to file a claim and get your benefits paid
- Your rights to appeal a claim payment or Medical Management decision
- What we mean by certain healthcare terms

Knowing the details can make a difference in how satisfied you are with your plan, and how easy it is for you to use. If you have additional questions, please visit [www.empireblue.com](http://www.empireblue.com) or call Member Services at 1-800-553-9603.

## Eligibility

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### WHEN ARE YOU ELIGIBLE?

Your coverage under Empire's plan begins on:

- Your group's effective date; or
- On the date you are eligible for group benefits as a new employee as determined by your employer.

Contact your Benefits Administrator for more information on eligibility rules.

### ELIGIBLE DEPENDENTS

The following family members are eligible for coverage under your plan:

- Your spouse
- Your unmarried children (including stepchildren)
  - Until the end of the calendar year in which each child reaches age 19, or
  - Until the end of the calendar year in which each child reaches age 23, as long as the child remains unmarried, is dependent on you, and is a registered full-time student at an accredited college or university (a dependent's full-time attendance at an accredited school of higher education must be documented annually), or
  - Until the child is no longer dependent on you or your spouse, or
  - Until the date of his or her marriage
- Your unmarried children, regardless of age, who are physically or mentally disabled as defined by New York Mental Hygiene Law, provided the condition started before the age when coverage would have normally ended. Empire will require that a physician certify the child's condition.

Your plan does not cover foster children.

### COVERAGE CATEGORY

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

- Individual, which covers only you
- Family, which covers you and one or more of the following:
  - Your spouse
  - Unmarried dependent children (natural or adopted)

### ADDING OR REMOVING A DEPENDENT

If you need to change coverage categories or add or remove a dependent, you should contact your Benefits Administrator for the appropriate forms. All changes to coverage must be in writing. Life events that might cause you to need to add or remove a dependent are:

- Having a baby
- Getting married
- Getting divorced

A newborn natural baby or an adopted baby in certain circumstances (see below) will automatically be covered under the plan if you have family coverage. However, you will need to add the baby's name as a covered dependent. If you do not have family coverage but notify Empire in writing within 30 days to change to family coverage, Empire will provide retroactive coverage during this period.

An adopted newborn is covered from the moment of birth if:

- You take custody as soon as the infant is released from the hospital after birth,
- The newborn is dependent upon you pending finalization of the adoption, and
- You file an adoption petition with New York State within 30 days of the infant's birth.

Adopted newborns will not be covered from the moment of birth if:

- The infant has coverage from one of the natural parents for the newborn's initial hospital stay
- A notice revoking the adoption has been filed
- One of the natural parents revokes their consent to the adoption

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

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

Qualified Domestic Relations Order (QDRO). A Domestic Relations Order that, at the determination of the Plan Administrator (generally the Employer/Sponsor of the group health plan), meets certain criteria established by law. The Qualified Domestic Relations Order creates or recognizes an alternate payee's right (generally the alternate payee is a spouse, former spouse, child or other dependent of the plan participant), or assigns to an alternate payee the right, to receive plan benefits that otherwise would have been payable to a plan participant.

You may request, without charge, the procedures governing the administration of a Qualified Medical Child Support Order or a Qualified Domestic Relations Order determinations 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.

# 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.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
<b>HOSPITAL</b>	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*
<b>MEDICAL</b>	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire
<b>AMBULANCE CHARGES</b>	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](http://www.empireblue.com).

### Tips for Filing a Claim

- File claims within 18 months of date of service.
- Visit [www.empireblue.com](http://www.empireblue.com) to print out a claim form immediately or contact Member Services at 1-800-553-9603 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!**

## IF YOU HAVE MEDICAL COVERAGE UNDER TWO PLANS (COORDINATION OF BENEFITS – COB)

Empire has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one health plan. The benefits provided by Empire will be coordinated with any benefits you are eligible to receive under the other plan.

Together, the plans will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

## Which Plan Pays Benefits First?

Here is how Empire determines which plan has primary responsibility for paying benefits:

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
  - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's healthcare expenses), the plan covering the parent with custody is primary.
  - If the parent with custody is remarried, his or her plan pays first, the step-parent's plan pays second and the non-custodial parent's plan pays third.
  - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's healthcare expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.
- If none of these rules apply, the plan that has covered the patient longest is primary.

## If Empire Is the Secondary Plan

If the Empire plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

## Tips for Coordinating Benefits

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

## If You Receive An Overpayment Of Benefits

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

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

## Health Care Fraud

Illegal activity adds to everyone's cost for healthcare. That's why Empire welcomes your help in fighting fraud. If you know of any person receiving Empire benefits that they are not entitled to, call us. We will keep your identity confidential. Want to see some recent examples of Empire's fraud prevention efforts? Visit [www.empireblue.com](http://www.empireblue.com).

**REMEMBER**

**FRAUD HOTLINE 1-800-I.C.FRAUD (423-7283) During normal business hours**

## If You Have Questions About a Benefit Payment

Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the claim other than your co-payment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or an Explanation of Benefits (EOB) citing the reasons your claim was reduced or denied.

The notification will give you:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary
- An explanation of claims review procedures

If you have any questions about your claim, your Benefits Administrator may be able to help you answer them. You may also contact Empire Member Services at 1-800-553-9603 or in writing for more information. When you call, be sure to have your Empire I.D. card number handy, along with any information about your claim. Send written inquiries to:

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

# Complaints, Appeals and Grievances

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## 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 healthcare services your plan offers, plan procedures or our customer service, call Member Services. Member Services may ask you to put your complaint in writing if it is too complex to handle over the telephone.

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

If your complaint, grievance or appeal concerns behavioral healthcare, call 1-800-635-6626 or write to:

**Empire BlueCross BlueShield**  
**P.O. Box 5110**  
**Grand Central Station**  
**New York, NY 10163-5110**  
**Attention: Behavioral Healthcare Program**

### Provider Quality Assurance

Because your healthcare 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 on the previous page.

### Your Right to Appoint a Representative

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

## STANDARD INTERNAL APPEALS

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

### Level 1 Appeals

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

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

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

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

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

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

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

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

**REMEMBER**

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

### **Expedited Level 1 Appeals**

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

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

### **Expedited Appeals may be filed by telephone and in writing.**

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

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

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

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

### **Level 2 Appeals and Timeframes**

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

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

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

### **EXTERNAL APPEALS**

As an alternative to filing a Level 2 Appeal with Empire, you may request an external review by a New York State Department of Insurance appeals agent. You can file an external appeal if benefits were denied:

- For lack of medical necessity
- Because the service was determined to be an experimental and/or investigational procedure

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



## To Obtain An External Appeal

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

- The New York State Department of Insurance at 1-800-400-8882 or [www.ins.state.ny.us](http://www.ins.state.ny.us)
- Empire Member Services at 1-800-553-9603

## Resolving an External Appeal

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

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

Submit your appeal within 45 calendar days:

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

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

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

## Standard External Review Process

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

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

## Expedited External Appeals

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

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

## LEVEL 1 GRIEVANCES

A grievance is a verbal or written request to review an adverse determination concerning an administrative decision not related to medical necessity. For example, a claim was denied because the member did not obtain precertification for services.

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

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

A qualified representative (including clinical personnel, where appropriate) who did not participate in the original decision will review your grievance.

We will make a decision within the following timeframes for 1<sup>st</sup> Level Grievances:

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

## LEVEL 2 GRIEVANCES

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire within 60 business days from receipt of the notice of the letter denying 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 2<sup>nd</sup> Level Grievance within 15 days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

We will make a decision within the following timeframes for 2<sup>nd</sup> Level Grievances:

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

## EXPEDITED GRIEVANCES

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

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

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

## DECISION ON GRIEVANCES

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

- The reason for Empire's decision
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision

## HOW TO FILE AN APPEAL OR GRIEVANCE

To submit an appeal or grievance, call Member Services at 1-800-553-9603, or write to the following address with the reason why you believe the administrative decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

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

# Ending and Continuing Coverage

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## WHEN COVERAGE ENDS

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

- Your group terminates the contract
- Your group no longer meets our underwriting standards
- Your group 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

## NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under your plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your eligible dependents, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under your plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under your Plan and under federal law, please review your plan's Summary Plan Description or contact your Plan Administrator.

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of your plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your covered spouse and your covered dependent children could become qualified beneficiaries if coverage under your plan is lost because of the qualifying event. Under your plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under your plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under your spouse's plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your covered dependent children will become qualified beneficiaries if they lose coverage under your plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under your plan as a "dependent child."

## 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 Fund Office 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.

## 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**

The Trustees of the Metal Trades Branch Welfare Fund reserve 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. 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

# 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 domestic relations order or 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 1-800-553-9603.

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. HealthLine is also equipped to provide assistance in most languages.

## CONFIDENTIALITY POLICY

In recognition of the need for member privacy, and in compliance with federal and state laws and regulations, Empire has a policy on the confidentiality of member medical information.

- Empire has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of member medical information, which is used, disclosed, exchanged or transmitted orally, in writing or electronically.
- Confidential member medical information is accessible only to those Empire employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Empire policies and procedures and federal and state laws and regulation concerning the request for use, disclosure, transmission, release, security, storage and destruction of confidential member medical information.
- Empire does not disclose our members' nonpublic personal information to any of our affiliates or to nonaffiliated third parties, except as permitted by law to allow us to conduct our business.
- Disclosure of confidential information to external vendors for purposes of payment or health care operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect member identification.
- Identifiable personal health information is not shared with your employer, unless permitted or required by law.
- Because Empire is not a provider of medical services, it generally does not maintain medical records created by your provider of service. If you require access to your provider's medical records, please contact your provider to arrange access.
- Empire contractually requires all of its network practitioners and providers to ensure the privacy and to protect the confidentiality of members' medical information.
- When you become covered under your Empire health benefit plan, you agree that Empire, or its designee, may use and/or disclose your confidential medical information for purposes of payment and healthcare operations as permitted or required by law or regulation. In addition, each Empire member agrees that any healthcare provider, healthcare payor or government agency shall furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made for use and/or disclosure by Empire to administer the terms of the health benefit plan.
- You may request access to any other information that is maintained by or for Empire by calling Member Services to arrange access. You may request an amendment of records maintained by and for Empire, or you may request an accounting of disclosures as permitted by law.
- Except as stated above and as may be permitted or required by law, Empire does not release confidential member medical information to anyone outside Empire without a specific "written authorization" to release, authorized by the member or member's designee, which may be revoked at any time. The authorization must be signed and dated and must specify:
  - The information that can be disclosed and to whom
  - What the information will be used for, and
  - The time period for which the authorization applies.

For additional information regarding the confidentiality of member medical information, please read Empire's Notice of Privacy Practices. Go to [www.empireblue.com](http://www.empireblue.com) and click on "Privacy Notices" at the bottom of the homepage. If you would like a printed copy of this policy please call Empire Member Services at the toll-free number on your identification card. Please refer to the Notice of Privacy Practices section for more information.

# Notice of Privacy Practices

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***EFFECTIVE DATE: APRIL 14, 2003***

***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.***

At Empire, we respect the confidentiality of your medical information and will protect that information in a responsible manner. We have a comprehensive privacy program in place that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, the government legislation that sets standards for the privacy of medical information. Empire follows all state privacy laws to which we are subject that do not conflict with the HIPAA Privacy Regulations. However, if a state privacy law conflicts with the HIPAA Privacy Regulations yet provides greater privacy rights or protections than the HIPAA Privacy Regulations, we will follow that state law.

We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the changes are permitted by law. Before we make a significant change to our privacy practices, we will change this notice and send the new one to our current subscribers. This new notice will be effective for all medical information that we maintain, including medical information we created or received before the changes were made.

Additionally, please know that Empire is required by law to maintain the privacy of your medical information and to give you this notice regarding your rights, our privacy practices and legal duties concerning your medical information.

## **DEFINITION OF MEDICAL INFORMATION**

When Empire refers to medical information in this notice, we mean information that is individually identifiable health information. This includes demographic information collected from you or created or received by a healthcare provider, a health plan, your employer or a healthcare clearinghouse.

This information relates to:

- (1) Your past, present or future physical or mental health or condition
- (2) The provision of health care to you, or
- (3) Past, present or future payments for the provision of healthcare to you.

## **USES AND DISCLOSURES OF MEDICAL INFORMATION**

This section provides you with a general description and examples of the ways your medical information is used and disclosed. Empire's uses and disclosures are not limited to these examples.

### **Treatment**

Your medical information may be used or disclosed to a physician or other healthcare provider in order for them to provide you with treatment

### **Payments**

Your medical information may be used or disclosed:

- For billing, claims management and collections activities.
- To pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan.
- To determine your eligibility for benefits.
- To conduct risk adjustment activities.
- To coordinate benefits.
- To determine medical necessity.
- To conduct utilization review activities.
- To obtain premiums.
- To issue explanations of benefits to the person who subscribes to the health plan in which you participate.
- To a health care provider or entity so they can obtain payment or engage in payment activities.

### **Health Care Operations**

Your medical information may be used and disclosed in connection with our health care operations, including:

- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of benefit coverage.



- Case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives, disease management or wellness programs and related functions that do not include treatment.
- Population-based activities relating to improving health or reducing health care costs.
- Quality assessment and improvement activities and protocol development.
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Conducting or arranging for medical review, legal services, auditing and fraud and abuse detection and compliance programs.
- Business planning and development, such as formulary development and administration.
- Business management and general administrative activities, including management activities relating to privacy, customer service and resolution of internal grievances.

### **Additional Disclosures**

Your medical information may be disclosed:

- To another entity that has a relationship with you for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.
- To other persons or entities that assist us in conducting our payment, health care operations and business activities. We will not disclose your medical information to those persons or entities unless they agree to keep it protected.

### **Health-Related Services**

Your medical information may be used to send you appointment reminders or to communicate with you to encourage you to purchase or use a health-related product or service (or payment for such product or service), that is provided by, or included in, an Empire health plan

This includes communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a benefit plan, for purposes of treatment, case management or care coordination, or to direct or recommend alternative treatments, therapies, health care providers or settings of care.

### **To Your Family and Friends**

Your medical information may be disclosed to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Your name, location and general condition or death may be used or disclosed to notify or assist in the notification of (including identifying or locating) a person involved in your care.

We will provide you with an opportunity to object to such uses or disclosures, unless, based on professional judgment, we may reasonably infer from the circumstances that you do not object to such uses and disclosures.

If you are not present, or in the event of your incapacity or an emergency, we will use our professional judgment in deciding whether disclosing your medical information would be in your best interest.

### **If You Are a Member of a Group Health Plan**

Your medical information, and the medical information of others enrolled in your group health plan, may be disclosed to your employer or the organization that sponsors your group health plan (the “plan sponsor”) in order to permit the plan sponsor to perform plan administration functions. Please see your plan documents for an explanation of these limited uses and disclosures.

Summary information about the enrollees in your group health plan may also be disclosed to the plan sponsor so they may obtain premium bids for health insurance coverage or in order to decide whether to modify, amend or terminate your group health plan. The information we may disclose summarizes claims history and expenses or types of claims experienced by the enrollees in your group health plan. This summary information will be stripped of demographic information but the plan sponsor may still be able to identify you or other enrollees.

### **Disaster Relief**

We may use or disclose your medical information to a public or private entity authorized by its charter or by law to assist in disaster relief efforts.

## **For the Public Benefit**

Your medical information may be used or disclosed as authorized by law for the following purposes:

- As required by law
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight and to employers regarding work-related illness or injury
- To report adult abuse, neglect or domestic violence
- To health oversight agencies
- In response to court and administrative orders and other lawful processes
- To law enforcement officials pursuant to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other person
- To coroners, medical examiners and funeral directors
- To organ procurement organizations
- To avert a serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state workers' compensation law

## **Marketing**

Your medical information may be used or disclosed to encourage you to purchase or use a product or service by face-to-face communication by us or for us to provide you with promotional gifts of nominal value.

## **Fundraising**

Your demographic information and the dates of health care services provided to you may be used in order to contact you for fundraising. We may disclose information to a business associate or foundation to assist us in our fundraising activities. We will provide you with fundraising materials and a description of how you may opt out of receiving future fundraising communications.

## **Your Written Authorization Is Required**

Other uses and disclosures of your medical information that are not described above will only be made with your written authorization. You may give us written authorization to use or to disclose your medical information to anyone for any purpose.

You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure that you permitted prior to your revocation.

## **Your Individual Rights**

**Access to Your Information:** You have the right to inspect or obtain a copy of the medical information about you that is contained in a "designated record set" except for psychotherapy notes and certain other information. A "designated record set" generally contains medical and billing records as well as other records that are maintained by or for us, or used by or for us to make decisions about you. We may ask you to submit your request in writing and to provide us with the specific information we need in order to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies to you. In certain situations, we may deny your request to inspect or obtain a copy of the requested information. If we deny your request, we will notify you in writing and may provide you with an opportunity to have the denial reviewed.

## **Accounting Disclosures**

You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations or those authorized by you as well as for certain other activities that occurred up to six years before the date of your request. However, you will not be able to obtain a list of disclosure instances that occurred prior to April 14, 2003; the date this notice is effective. Any list we send you will include the date(s) of the disclosure, to whom it was made, their address, if known, a brief description of the information disclosed and the purpose of the disclosure. If you request this accounting list more than once in a 12-month period, we may charge you a reasonable administration fee for these additional requests.

## **Restrictions on Use or Disclosure**

You have the right to request that we restrict the use or disclosure of your medical information in connection with treatment, payment and health care operations. You also have the right to request that we restrict disclosures to persons involved in your health care or payment for your health care. We may ask you to submit your request in writing. We will review your request, but we are not required to comply with it.

## **Confidential Communications**

You have the right to request that we communicate with you about your medical information by a different means or location. You must make your request in writing and state that the information could endanger you if it is not communicated by a different means or location. We must accommodate your request if it is reasonable and specifies the new means or location of contact. It must also allow us to collect premiums and pay claims. This includes issuing explanations of benefits to the subscriber of the health plan in which you participate.

An explanation of benefits issued to the subscriber about the subscriber or others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though we communicated with you in the confidential manner you requested. Once your request for confidential communications is in effect, all of your medical information will be communicated in accordance with your instructions.

## **Amending Your Medical Information**

If you believe that the medical information contained in your “designated record set” is not correct or complete, you have the right to request that we amend it. We may require your request be in writing and that it explains why the information should be changed. If we make the amendment, we will notify you. In addition, if we make the change, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

If your request is denied, you will be notified in writing of the reason for the denial and the letter will explain how to file a written statement of disagreement. Empire has the option to rebut your statement. You have the right to ask that your original request, our denial and your statement of disagreement be included with any future disclosures of your information.

## **Additional Copies, Questions or Complaints**

### **Requests for Additional Copies and Questions Regarding Privacy and Individual Rights:**

- You may request a copy of our notice at any time.
- If you view this notice on our website or receive it by e-mail, you are also entitled to receive it in written form.
- You may request more detailed information about your rights and privacy protections or learn how to exercise those individual rights as described in this notice.

Please contact Member Services at the phone number listed on the back of your member identification card or write to us at P.O. Box 1407, Church Street Station, New York, NY 10008-1407.

## **Complaints**

If you believe that Empire has violated your privacy rights, write to our Privacy Office at P.O. Box 1407, Church Street Station, New York, NY 10008-1407 or call Member Services at the phone number listed on the back of your member identification card.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.

# HIPAA Privacy Requirements

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## EMPLOYER/SPONSOR

1. Under the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations (45 C.F.R. Parts 160 and 164), referred to as HIPAA, the Employer/Sponsor of a Group Health Plan (the “Plan”) may obtain and use a member’s summary information<sup>1</sup> for purposes of obtaining premium bids, to modify, amend or terminate the Plan, and for enrollment and eligibility determinations.

Under the requirements of HIPAA, the Employer/Sponsor may obtain and use a member’s Protected Health Information, including electronic protected health information (PHI)<sup>2</sup>, for purposes of Plan Administration. To the extent the Employer/Sponsor requires PHI, and prior to receiving PHI, the Employer/Sponsor shall certify to the Plan that the Plan Documents meet the requirements of HIPAA (as described below).

## EMPLOYER/SPONSOR OBLIGATIONS

2. The Employer/Sponsor agrees to comply with the following in order to obtain PHI about members for the permissible limited uses or disclosures for the Plan administration functions it performs.

### Purpose of Disclosure to Employer/Sponsor

- (a) The Plan and any health insurer or HMO will disclose members’ PHI to the Employer/Sponsor only to permit the Employer/Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Employer/Sponsor of members’ PHI will be subject to and consistent with the provisions of this section.
- (b) Neither the Plan nor any health insurance issuer or HMO will disclose members’ PHI to the Employer/Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the members.
- (c) Neither the Plan nor any health insurance issuer or HMO will disclose members’ PHI to the Employer/Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Employer/Sponsor.

### Restrictions on Plan Sponsor’s Use and Disclosure of PHI

3.
  - (a) The Employer/Sponsor will neither use nor further disclose members’ PHI, except as permitted or required by the Plan Documents, as amended or required by law.
  - (b) The Employer/Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI.
  - (c) The Employer/Sponsor will ensure that any agent, including any subcontractor, to whom it provides members’ PHI, agrees to these restrictions and conditions, including implementing reasonable and appropriate security measures in the Plan Documents, with respect to members’ PHI.
  - (d) The Employer/Sponsor will not use or disclose members’ PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Employer/Sponsor.
  - (e) The Employer/Sponsor will report to the Plan any use or disclosure or security incident of members’ PHI that is inconsistent with the allowed uses and disclosures promptly upon learning of such inconsistent use or disclosure.
  - (f) The Employer/Sponsor will make PHI available to the member who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524, Access of Individual to PHI.
  - (g) The Employer/Sponsor will make members’ PHI available for amendment, and will on notice amend members’ PHI, in accordance with 45 Code of Federal Regulations § 164.526, Amendment of PHI.
  - (h) The Employer/Sponsor will track disclosures it may make of members’ PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528, Accounting of Disclosures of PHI.
  - (i) The Employer/Sponsor will make its internal practices, books, and records, relating to its use and disclosure of members’ PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
  - (j) The Employer/Sponsor will, if feasible, return or destroy all member PHI, in whatever form or medium (including in any electronic medium under the Employer’s/ Sponsor’s custody or control), received from the Plan that the

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<sup>1</sup> Summary information summarizes the claims history, claims expenses, or types of claims of individuals covered under a group health plan, and from which individual identifiers have been removed.

<sup>2</sup> Health information that is received, created, maintained or transmitted in electronic form or in any other form or medium by a health plan, insurer or HMO that identifies the individual or can be used to identify the individual and that relates to an individual’s physical or mental health or condition, including information related to an individual’s care or the payment for such care.

Employer/Sponsor still maintains, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the members' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all members' PHI, the Employer/Sponsor will limit the use or disclosure of any member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

#### **Adequate Separation between the Employer/Sponsor and the Plan**

4. (a) The Employer/Sponsor will ensure the adequate separation between employees and the Plan, supported by reasonable and appropriate security measures.
  - 1) All employees or classes of employees or other workforce members under the control of the Employer/Sponsor may be given access to or may receive members' PHI relating to payment under or health care operations of the Plan, or other matters pertaining to the Plan in the ordinary course of business.
  - 2) The employees, classes of employees or other workforce members identified above will have access to members' PHI only to perform the Plan administration functions that the Employer/Sponsor provides for the Plan.
- (b) The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer/Sponsor, for any use or disclosure or security incident of members' PHI in breach or violation of or noncompliance with these provisions of the Plan Documents. The Employer/Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(e), and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy or security of whose PHI may have been compromised by the breach, violation or noncompliance.

# Definitions

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Refer to these definitions to help you better understand your coverage. Need more help? Additional terms and definitions can be viewed at [www.empireblue.com](http://www.empireblue.com).

## **Adverse Determination**

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

## **Allowed Amount**

The maximum Empire will pay for a covered service out-of-network. The allowed amount is based on an agreement between Empire and the provider, or if there is no agreement, then on the customary charge or the average market charge in your geographic area for a similar service. You are responsible for paying the entire portion above the allowed amount.

## **Ambulatory Surgery**

See "same-day surgery."

## **Annual Out-of-Pocket Coinsurance Maximum**

The most you will have to pay in out-of-pocket costs for coinsurance on covered services received during a calendar year. When you meet the out-of-pocket coinsurance maximum, the plan pays 100% of the allowed amount for covered expenses for the remainder of that calendar year. Your co-payments, deductible, the coinsurance for behavioral healthcare expenses, and any amount you pay above the out-of-network allowed amount do not count toward your annual out-of-pocket coinsurance maximum.

## **Authorized Services**

See "precertified services."

## **BlueCard® Program**

The BlueCard Program helps reduce your costs when you obtain out-of-network care outside of the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan ("local Blue Plan"). Just show your Empire ID card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.

When you obtain healthcare through the BlueCard Program, the portion of your claim that you are responsible for ("member liability") is, in most instances, based on the **lower** of the following:

- the billed amount that the participating provider actually charges for covered services, or
- the negotiated price that the local Blue Plan passes on to Empire.

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

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

The negotiated price may reflect:

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

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

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

If you have any questions about the BlueCard Program, contact Member Services.

## **BlueCard® PPO Program**

Nationwide, Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other healthcare providers. As a PPO member, you have access to these networks through the BlueCard PPO Program to receive in-network benefits for covered services. By presenting your Empire I.D. card to a provider participating in the BlueCard PPO Program, you receive the same benefits as you would receive from an Empire PPO network provider. The suitcase logo on your I.D. card indicates that you are a member of the BlueCard PPO Program. Call 1-800-810-BLUE (2583) or visit [www.bcbs.com](http://www.bcbs.com) to locate participating providers.

## **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<sup>®1</sup> 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 allowed amount.

## **Co-payment**

The fee you pay for office visits and certain covered services when you use in-network providers. The plan then pays 100% of remaining covered expenses.

## **Covered Services**

The services for which Empire provides benefits under the terms of your contract. For example, Empire covers one in-network annual physical exam.

## **Deductible**

The dollar amount you must pay each calendar year before your plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, your PPO plan will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit – if two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.

## **Hospital/Facility**

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

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

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

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

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

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

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

Empire does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.

### **In-Network Benefits**

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

### **In-Network Provider/Supplier**

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is in Empire's PPO network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

### **Itemized Bill**

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

### **Lifetime Maximum**

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

### **Medically Necessary**

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

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

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

### **Non-Participating Hospital/Facility**

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's PPO contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

### **Operating Area**

Empire operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.



## **Out-of-Network Benefits**

Reimbursement for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs.

## **Out-of-Network Deductible and Coinsurance**

Out-of-network benefits for all services are paid after you meet an individual or family *out-of-network* deductible. Once your out-of-network deductible is met, you and the plan share the cost. You and the plan each pay a percentage, called coinsurance, of Empire's allowed amount for the *out-of-network* service. You are responsible for any amounts not covered, or which are in excess of the allowed amount. You pay your *out-of-network* coinsurance up to an annual out-of-pocket maximum. Once you meet your annual *out-of-network* out-of-pocket coinsurance maximum, you will not be required to pay coinsurance, but you will be responsible to pay the difference between the provider's actual charge and Empire's allowed amount. This is not applied to the deductible and coinsurance amounts. Refer to Your *Benefits at a Glance* section for your *out-of-network* deductible, coinsurance and out-of-pocket maximum amounts.

## **Out-of-Network Providers/Suppliers**

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is not in Empire's PPO network
- Is not in the PPO network of another Blue Cross and/or Blue Shield plan
- Does not have a negotiated rate with another Blue Cross and/or Blue Shield plan

## **Outpatient Surgery**

See "same-day surgery."

## **Participating Hospital/Facility**

A hospital or facility that:

- Is in Empire's PPO network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

## **Plan Administrator**

The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. Empire is not the Plan Administrator. To identify your Plan Administrator, contact the Fund Office or health plan sponsor.

## **Precertified Services**

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by your plan. For example, planned inpatient surgery, MRIs and MRAs. Failure to precertify may result in a reduction or denial of benefits.

## **Provider**

A hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for covered services within the scope of the practitioner's license.

For behavioral healthcare purposes, "provider" includes care from psychiatrists, psychologists or certified social workers (with three or more years of post-degree supervised experience), providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

## **Same-Day Surgery**

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital.

## **Treatment Maximums**

Maximum number of treatments or visits for certain conditions. Maximums for in-network and out-of-network services are combined. For example, if the plan has a limit of 30 visits on a covered expense, you would reach the limit if you had 17 visits in-network and 13 visits out-of-network.

# HealthLine Recorded Topics

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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 HealthLine Recorded Topics at 1-877-TALK-2RN (825-5276). See the Health Management section for more information on HealthLine and instructions on how to listen to the tapes. These are our most requested audiotapes; there are more than 1,100 available. If you do not see the topic that interests you, just ask one of the HealthLine nurses.

## **Aging**

- 7805 Alzheimer's Disease
- 7845 Impotence in Older Men
- 7878 Sleep Problems

## **Alcohol Problems**

- 4131 Alcoholism – Causes
- 4133 Alcoholism - The Disease of Denial

## **Arthritis**

- 4172 Arthritis Or Rheumatism?
- 4171 Arthritis Symptoms
- 4175 Osteoarthritis

## **Back and Neck**

- 4192 Back Pain – Causes
- 4193 Exercises for the Desk Bound
- 4199 Neck Pain

## **Blood and Circulatory**

- 4211 Anemia
- 6104 Aneurysms

## **Bones, Joints and Muscles**

- 4239 Gout

## **Cancer**

- 6417 Colon Cancer
- 6429 Leukemia – Chronic
- 6481 Pancreatic Cancer
- 6453 Seven Warning Signs of Cancer
- 6459 Stomach Cancer
- 6465 Throat Cancer
- 6486 Thyroid Cancer

## **Cardiovascular Health**

- 6101 Abnormal Heartbeat
- 6113 Chest Pain (Other Than Angina)
- 6116 Cholesterol - "Good" and "Bad"
- 6119 Congestive Heart Failure
- 6129 Early Warning of Heart Attack
- 6144 High Blood Pressure And Heart Disease
- 6170 Triglycerides

## **Common Illnesses**

- 4332 Eczema

## **Digestive System**

- 5400 Anal Fissure and Fistulas
- 4411 Colitis
- 4412 Constipation in the Digestive System
- 5402 Crohn's Disease
- 4413 Diarrhea in the Digestive System

## **Digestive System (continued)**

- 4422 Diverticulosis and Diverticulitis
- 5404 Gallbladder Disease
- 5406 Gastroenteritis
- 4415 Heartburn and the Digestive System
- 4416 Hemorrhoids
- 5411 Intestinal Gas
- 4419 Irritable Bowel Syndrome
- 5414 Pancreatitis
- 5416 Rectal Bleeding
- 4421 Ulcers – Overview

## **Ear, Nose and Throat**

- 4453 Ear Wax (Cerumen)
- 4456 Ringing in the Ear – Causes
- 4457 Sinus Problems

## **Eyes and Vision**

- 4512 Double Vision
- 4513 Eye Symptoms Demanding Immediate Attention
- 4517 Spots and Floaters

## **Hormonal Disorders**

- 4701 Hyperthyroidism (Overactive Thyroid)
- 4702 Hypothyroidism (Underactive Thyroid)

## **Infectious Diseases**

- 4735 Fifth Disease
- 4724 Lyme Disease

## **Men's Health**

- 4764 Prostate Problems

## **Mental and Emotional Health**

- 6707 Anxiety
- 6717 Depression and its Symptoms
- 6720 Exhibitionism
- 6725 Grief and Loss
- 6733 Kleptomania
- 6735 Letting Go of Resentment
- 6737 Manic or Bipolar Depression
- 6744 Narcissism
- 6745 Nervous Breakdown
- 6748 Obsession and Compulsion
- 6749 Panic Attacks
- 6763 Schizophrenia
- 6773 Suicide
- 6777 Voyeurism

## **Respiratory Problems**

- 4933 Chronic Cough - A Significant Respiratory Problem
- 4934 Emphysema

**Sexually Transmitted Diseases**

- 4951 Chlamydia
- 4953 Herpes
- 4955 Syphilis

**Skin Health**

- 4975 Psoriasis

**Sports Medicine**

- 7462 Tendonitis

**Stress and How to Cope**

- 5131 10 Stress Busters You Can Do
- 5132 Burnout - Is It Happening to You?
- 5133 Facing Financial Troubles
- 5135 Mental Exercises For Stress Management
- 5138 Stress – What Is It?

**Symptoms**

- 6127 Dizziness as a Symptom

**Teenage Concerns**

- 5227 Homosexuality
- 5228 Masturbation
- 5226 Think You're Gay

**Tests and Examinations**

- 6418 Colonoscopy
- 6131 Echocardiography
- 5241 Endoscopic Retrograde  
Cholangiopancreatography (ERCP)
- 7465 Thyroid Tests

**Urinary and Genital Systems**

- 5261 Bladder Stones
- 5262 Blood in Urine
- 5267 Women and Urinary Infections

**Weight Control**

- 6911 Choosing a Commercial Diet Program
- 6981 Teaching Your Body to Burn More Calories

**Women's Health**

- 7134 Hot Flashes
- 7135 Hysterectomy
- 7144 Menopause Problems?
- 5313 Sexual Response in Women
- 7191 Yeast Infections

**Other Categories:**

- Allergies
- Brain and Nervous System
- Child Health and Development
- Cosmetic and Reconstructive Surgery
- Dental Health
- Diabetes
- Drug Abuse
- Eating Disorders
- Exercise and Fitness
- Family Planning
- Foot Care
- General Health
- Genetic Disorders and Birth Defects
- Headaches
- Health Quizzes
- Hearing
- HIV Infection/AIDS
- Medications
- Neurology
- Newborn Care
- Parenting and Family Life
- Personal Safety
- Pregnancy and Childbirth
- Preparing for Emergencies
- Surgery

# Amendment To Member's Evidence Of Coverage

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Empire HealthChoice Assurance, Inc.  
11 West 42nd Street  
New York, New York 10036

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.  
11 West 42nd Street  
New York, New York 10036

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:

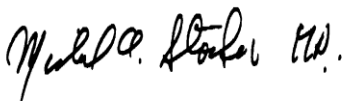
All benefits of the group contract and your evidence of coverage are payable to the insured. Payments under the group contract and evidence of coverage for services provided by participating providers will be made directly to the participating provider.

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



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Michael A. Stocker, M.D.  
Chief Executive Officer,  
Empire HealthChoice, Inc



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Michael A. Stocker, M.D.  
Chief Executive Officer,  
Empire HealthChoice Assurance, Inc.