Empire BlueCross BlueShield

Individual and family health benefit plans for New York

We make it easy. Find out how.

Core, Essential, Preferred and Premier plans

Note: The plans described here are available for effective dates starting January 1, 2014. They can be purchased from Empire directly. Open Enrollment begins October 1, 2013.
This document contains a brief summary of certain benefits and services covered under Empire policies. It is important to consult the Evidence of Coverage issued by Empire for complete coverage details. It contains important exclusions, limits and other coverage terms that are not contained here.

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Health care may never be simple, but choosing the right plan can be.

When it comes to Individual health care coverage, it's not one-size-fits-all. With Empire BlueCross BlueShield (Empire), you get a wide range of options so you can compare plans and find the best coverage for your needs and budget. No one knows what you and your family need better than you. Just let us know and we're here to help when and where you need us.

To learn more about your options, review this information with your Empire authorized representative.

Total health care

We offer you a total health solution, so you can live healthier, feel better and save money doing it. With Empire, you get:

- Easy-to-use tools to find a doctor, hospital, provider or pharmacy
- No-cost preventive care, like checkups and flu shots
- 24/7 NurseLine
- Online support to manage your plan
- Reliable customer service

Network value

Access to quality doctors in your area is important. And we've created our network of doctors and hospitals with this in mind. Our goal is to work with doctors and hospitals who will offer the most quality care possible — at a competitive cost. Our Pathway Enhanced network includes:

- Doctors and hospitals
- Lab, durable medical equipment and behavioral health providers
- Urgent and emergency providers

A friendly face in a changing world

Health care is changing but one thing is clear: we're here to provide health care benefits to people like you — now and in the future. Starting in 2014, all Americans must have health coverage. In fact, you can't be turned down! You can purchase coverage direct from Empire or through the NY State of Health - The Official Health Plan Marketplace. In some cases, the government may even help pay for your coverage. Get the health care coverage you need from Empire.

Get help today!

Call your Empire authorized representative or visit us online at empireblue.com where you can view and compare plan options.

How Health Care Coverage Works

Health care coverage can help protect you against the high costs of care. With most health care coverage, you pay a monthly fee called a premium, then you share some of the cost of covered care with the company that provides your coverage. With Empire, you can choose the level of cost sharing that works best for your health care needs and budget.

Here's an example: *Meet John*

John's story is only an example of how health plans work. Be sure to look at the benefits for each of our plan choices for specific information.

John's health plan has the following benefits:

- $35 copay for doctor visits.
- $2,000 deductible.
- 30% coinsurance.
- $5,000 out-of-pocket limit.

After injuring his knee in a soccer game, John calls his doctor. He chooses providers in our network, which saves him the most money. By choosing providers in our network, John gets lower negotiated rates (meaning, discounted prices). In the following examples, you'll see what John paid and why it's important to have health insurance.

Copay (Copayment)

On some plans you pay a fixed dollar amount for certain services when you get them. For example, when you see a doctor, you may be asked to pay a $35 copay.

Let's take a closer look at John's doctor's visit copay:

- *Doctor visit cost (without insurance):* $200
- *Empire's negotiated rate:* $140
- *Empire pays:* $105
- *What John paid:* $35 (his plan's copay for doctor office visit)

Deductible

You pay this amount for covered medical services each year. Covered services that apply to the deductible may include lab work, X-rays, office visits, anesthesia and surgeon fees. (Covered preventive services start before the deductible is met.) Your deductible starts over each year.

Please note:

For non-HSA plans, each family member has an individual deductible and out-of-pocket limit. The family deductible and out-of-pocket limit can be satisfied by two or more members. No one person can contribute more than his or her individual deductible or out-of-pocket limit. For HSA qualified plans, either one or more family members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket limit can be met by either one or more members. Once the limit is met, no additional coinsurance will be required for the family for the remainder of the year.

Here's what happens next when John's doctor orders an approved MRI of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- *Empire's negotiated rate:* $1,000
- *What John paid:* $1,000 (John's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *Empire's negotiated rate:* $35,000
- *What John paid:* $1,000 (John's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

Coinsurance

Once you've met your deductible, Empire starts paying a portion of claims. The health care bills that remain are shared between you and Empire. Your coinsurance is the percent that you must pay for a covered service per year. Having met his deductible, John's coinsurance begins.

Let's check in to see what John will be paying.

- *Coinsurance:* 30% (30% of $34,000 = $10,200)
- *What John paid:* $2,965 (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)

Out-of-pocket limit

The most you pay during a policy period before your health insurance begins to pay at 100% (of the allowed amount). The amounts you pay for your deductible, coinsurance and copay are typically what make up your out-of-pocket limit. Once you meet your out-of-pocket limit, we pay 100% (of the allowed amount) of covered services for the rest of the year.

John has met his out-of-pocket and the remaining surgery costs are paid.

- *Empire pays:* $31,035
- *Out-of-pocket limit:* $5,000

Summary

John paid far less out-of-pocket because he had health care coverage. If John had used a provider outside of our network, depending on his plan, he might not have had coverage or would have had to pay much more.

- *Total for doctor visit, MRI and surgery (without health insurance):* $51,700
- *Total Empire paid after discounts:* $31,140
- *Total John paid:* $5,000

Covering you A to Z

All of our plan options have one major goal in mind: Making sure you stay healthy and that you get access to the quality care you need when you need it. That's why, no matter which plan you choose, you're covered for preventive care to emergencies, and more!

What's covered?

- [1]Preventive and wellness services and help managing a chronic (ongoing) disease
- Outpatient (ambulatory) patient care
- Emergency services, like going to the ER or urgent care
- Inpatient care (when you stay overnight in a hospital)
- Laboratory services
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)

Don't forget dental and vision coverage. Check out our Empire dental and vision plans. Just call your Empire authorized representative or go online to empireblue.com for details.

A closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand your prescription drug plan and the choices you have when it comes to selecting and paying for these medications.

To find out if your medication is covered, take a look at our drug list at empireblue.com > Customer Support > Forms Library > Empire Select Drug List. Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. By selecting a Tier 1 medication, you may have a lower cost share. You can usually save money by selecting a generic version of a medication. Or even save time by having medicine sent right to your home. Always talk to your doctor first about which medication is right for you.

Please visit our Find a Doctor tool on empireblue.com to see if your pharmacy is in-network.

Access coverage – no matter where you are in the U.S. – with BlueCard®

When you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to happen. However, our plans cover emergency and urgent care in every state through the Blue Cross and Blue Shield Association's BlueCard® Program.

Take care of yourself with no-cost preventive care

Empire's preventive care coverage options give you access to any of our network doctors so you pay nothing out of pocket. Stay in control of your health care and your finances with $0 deductible, $0 copay and $0 cost to you for covered preventive services received in-network.

[1]Preventive and wellness services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Your plan options

We offer plans to fit your health care coverage needs — and your budget. To make it easy to compare and choose a plan, they are split into four different levels — Core, Essential, Preferred and Premier. Your costs and coverage increase with each level.

Core	With the Core plans, you pay less for your monthly premium but you pay more when you get care. You have broad benefits with deductibles, copays and coinsurance that may be higher than the other plans.
Essential	The Essential plans still have lower monthly premiums but you pay less when you get care.
Preferred	With the Preferred plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Core and Essential plans.
Premier	You enjoy the highest level of benefits and often pay less when you get care. However, you pay the highest monthly premiums with the Premier plan.

Make your health care dollars work harder with a Health Savings Account

A Health Savings Account (HSA) is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post-tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. HSA-compatible health care plans work with or without this savings account, the choice is yours.

Plan choices that are HSA-compatible include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you and check out the insert from our preferred banking partner.

What doctors can I see?

The health care plans we offer are **Guided Access** plans. **Guided Access** is a type of plan where you choose a primary care physician (PCP). Having a primary physician you see anytime you need a checkup or have a health issue is a good idea. You have a choice of in-network PCPs and a referral from your PCP is required to see other doctors and receive other services.

What is an in-network provider?

When you need care, you will get the best value by visiting an **in-network** doctor, hospital or other health care provider. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you're paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with your health plan to provide services at a negotiated rate. **Our plans do not offer out-of-network benefits (with the exception of emergency and urgent care or when we authorize care).** This means you will pay the entire cost for any service you get from **out-of-network** providers.

To find out if your current health care provider is in our network, visit our Find a Doctor tool on empireblue.com.

Easy-to-use online tools

Empire's website is an easy-to-use resource that allows you to manage your health care in a simple and convenient way. With our website, you can:

- Find out what is and isn't covered by your plan with an easy-to-understand breakdown of your benefits summary.
- Get instant access to your recent claims and coverage details.
- Know your costs before having certain procedures with clear estimates using our out-of-pocket cost calculator.

Get help from nurses 24/7

Empire's 24/7 NurseLine gives you access to trained registered nurses any time of the day or night for answers to your general health questions, to help you understand your symptoms and to help you determine the right care at the right time.

Find a Doctor

Want to make sure your doctor is in our network? Need to find a new doctor or specialist? No problem! Our online Find a Doctor Tool helps you find doctors, hospitals, pharmacies and other specialists in your area — and shows whether they are cost-saving network providers. Log on to empireblue.com anytime or download our mobile app right to your phone, so you can search for doctors when you're on the go.

Zagat® Health Survey

It's similar to the restaurant survey. See what other patients have said about the doctors and hospitals you're thinking about using. Add your own doctor reviews, too!

Access cost and quality information with Estimate Your Cost

Save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to compare quality and safety.

Save time and money with an urgent care center or retail health clinic

You can save money — and usually lots of time — by going to places other than the emergency room (ER) when your condition is not an emergency. The Find a Doctor tool can help find alternatives to the ER like urgent care centers, walk-in doctors' offices and retail health clinics.

Tips for picking a health plan

Choosing the right health care coverage is an important decision. Before you choose a plan, consider these tips. And remember, your Empire authorized representative is here to answer any questions.

- **Make sure the plan will meet your health care coverage needs**. Think about how often you see doctors and specialists. What prescription medications do you take?
- **If staying with your current doctors is important**, see if they're in our network by using our online Find a Doctor tool at empireblue.com. Seeing an in-network doctor can save you a lot of money on your health care.
- **Figure out your family's budget for coverage**. Some people would prefer to pay more in premium each month and less out of pocket each time for services like doctors' visits or lab work. Plans may offer different deductible, coinsurance and copay options so you can choose the level of cost sharing that best meets your health care coverage needs and budget.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. Talk to your financial advisor about potential tax advantages.

Do I qualify to get help paying for my health insurance?

Before you choose a plan, it's a good idea to find out if you qualify to get help paying for your health insurance. If you do qualify, it may make more sense for you to choose an Empire plan available through the NY State of Health Marketplace. Whether you choose an Empire plan offered through the NY State of Health Marketplace or direct through Empire, we have great plan options for you.

When can I purchase a plan?

Plans can be purchased once a year through an open enrollment period. This year, open enrollment is from October 1, 2013, to December 15, 2013, for a January 1, 2014 effective date. You may also enroll from December 16, 2013 through March 31, 2014, for effective dates after January 1, 2014. Check with your Empire authorized representative for effective date options and guidelines around enrollment during other times of the year.

How do I enroll in an Empire plan?

- If you are ready to enroll or would like more information about the health care plans offered by Empire, call your Empire authorized representative today!
- Visit our website at empireblue.com and apply online.

Empire BlueCross BlueShield

Get help today!

Call your Empire authorized representative or visit us online at empireblue.com where you can view and compare plan options.

We want you to be satisfied

After you enroll in a plan offered by Empire you will receive a Contract that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you change your mind, you may cancel your contract and your premium will be refunded, less any claims that were already paid.

This document is only a brief summary of benefits and services. Consult the Evidence of Coverage for complete coverage details, including important exclusions, limitations and terms. You may also:

- Check the benefit certificate and any riders to the policy for complete coverage terms and conditions.
- See the coverage details document included with this brochure.
- Call your Empire authorized representative.
- Go to empireblue.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

A high deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

ACS | BNY Mellon is an independent corporate entity that provides banking administration on behalf of Empire BlueCross BlueShield.

Coverage Details for New York

Things you need to know before you buy....

***Empire Core Guided Access, Empire Core Guided Access with Child Dental, Empire Core Guided Access for Child Only, Empire Core Guided Access for Child Only with Child Dental, Empire Essential Guided Access, Empire Essential Guided Access with Child Dental, Empire Essential Guided Access with HSA, Empire Essential Guided Access with HSA and Child Dental, Empire Essential Guided Access for Child Only, Empire Essential Guided Access for Child Only with Child Dental, Empire Preferred Guided Access, Empire Preferred Guided Access with Child Dental, Empire Preferred Guided Access for Child Only, Empire Preferred Guided Access for Child Only with Child Dental, Empire Premier Guided Access, Empire Premier Guided Access with Child Dental, Empire Premier Guided Access for Child Only, Empire Premier Guided Access for Child Only with Child Dental**

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Who is Covered Under Your Contract

You, the subscriber to whom your Contract is issued, are covered under your Contract. You must live, work, or reside in our service area to be covered under your Contract. If you are eligible for Medicare, You are not eligible to purchase a Contract.

Types of Coverage

In addition to Individual coverage, Empire offers the following types of coverage:

Individual and spouse - If you selected individual and spouse coverage, then you and your spouse are covered.

Parent and child/children – If you selected parent and child/children coverage, then you and your child or children, as described below, are covered.

Family – If you selected family coverage, then you, your spouse and your children, as described below, are covered.

Children Covered Under Your Contract

If you selected parent and child/children or family coverage, "children" covered under your Contract include your natural children, legally adopted children, step children, and children for whom you are the proposed adoptive parent without regard to financial dependence, residency with you, student status or employment. A proposed adopted child is eligible for coverage on the same basis as natural child during any waiting period prior to the finalization of the child's adoption. Coverage lasts until the end of the month in which the child turns 26 years of age. Coverage also includes children for whom you are a legal guardian if the children are chiefly dependent upon you for support and you have been appointed the legal guardian by a court order. Foster children and grandchildren are not covered.

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

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

Domestic Partner Coverage

Your Contract covers domestic partners of subscribers as spouses. If you selected family coverage, "children" covered under your Contract also includes the children of your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
   a. The affidavit must be notarized and must contain the following:
      - The partners are both eighteen years of age or older and are mentally competent to consent to Contract.
      - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
      - The partners have been living together on a continuous basis prior to the date of the application;
      - Neither individual has been registered as a member of another domestic partnership within the last six months; and

   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

   c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account
      - A joint credit card or charge card
      - Joint obligation on a loan
      - Status as an authorized signatory on the partner's bank account, credit card or charge card
      - Joint ownership of holdings or investments

- Joint ownership of residence
- Joint ownership of real estate other than residence
- Listing of both partners as tenants on the lease of the shared residence
- Shared rental payments of residence (need not be shared 50/50)
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
- Shared household budget for purposes of receiving government benefits
- Status of one as representative payee for the other's government benefits
- Joint ownership of major items of personal property (e.g., appliances, furniture)
- Joint ownership of a motor vehicle
- Joint responsibility for child care (e.g., school documents, guardianship)
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
- Execution of wills naming each other as executor and/or beneficiary
- Designation as beneficiary under the other's life insurance policy
- Designation as beneficiary under the other's retirement benefits account
- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Open Enrollment

You can enroll under your Contract during an initial open enrollment period that runs from October 1, 2013 through March 31, 2014. If Empire receives your selection between October 1, 2013 and December 15, 2013, your coverage will begin on January 1, as long as your applicable premium payment is received by then. If your selection is received by Empire between the first and fifteenth day of the month of January, February, or March of 2014, your coverage will begin on the first day of the following month, as long as your applicable premium payment is received by then. If your selection is received by Empire between the sixteenth and last day of the month of December 2013, January, February, or March of 2014, your coverage will begin on the first day of the second month, as long as your applicable premium payment is received by then.

You can enroll under your Contract during an annual open enrollment period that runs from October 15 through December 7. If Empire receives your selection between these dates, your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

If you do not enroll during open enrollment, or during a special enrollment period as described below, you must wait until the next annual open enrollment period to enroll.

Special Enrollment Periods

Outside of the annual open enrollment period, you, the subscriber, your spouse, or child, can enroll for coverage within 60 days of the occurrence of one of the following events:

- You or your spouse or child loses minimum essential coverage;
- Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan;
- You adequately demonstrate to Empire that another health plan in which you were enrolled substantially violated a material provision of its Contract;
- You move and become eligible for new health plans;
- You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption;
- You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
- You, your spouse or child exhausted your COBRA or continuation coverage.

Empire must receive notice and we must receive premium payment within 60 days of one of these events.

If you enroll because you lost minimum essential coverage or because you got married, your coverage will begin on the first day of the month following your loss of coverage or marriage.

If you have a newborn or adopted newborn child and we receive notice of such birth within 60 days thereafter, coverage for your newborn starts at the moment of birth; otherwise coverage begins on the date on which we receive notice. Your adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, Empire will not provide hospital benefits for the adopted newborn's initial hospital stay if one of the infant's natural parents has coverage for the newborn's initial hospital stay. If you have individual or individual and spouse coverage you must also pay any additional premium for parent and child/children or family coverage within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which we receive notice and the premium payment.

In all other cases, the effective date of your coverage will depend on when we receive your selection. If your selection is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month, as long as your applicable premium payment is received by then. If your selection is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month, as long as your applicable premium payment is received by then.

Network Providers

Your Contract only covers in-network benefits. To receive in-network benefits you must receive care exclusively from participating providers in our Pathway Enhanced network. Care covered under your Contract (including hospitalization) must be provided, arranged or authorized in advance by your primary care physician and, when required, approved by Empire. In order to receive benefits under your Contract, you must contact your primary care physician before you obtain covered services except for services to treat an emergency or services from a non-participating provider outside our service area for an urgent condition (described in Section VI. Covered Services section of your Contract) or care provided by your PCP. Specialist care requires a PCP referral. Except for care for an emergency condition (described in Section VI of your Contract) or care approved by us, you will be responsible for paying the cost of all care that is provided by non-participating providers.

How to Find a Provider in the Network

To find out if a provider is a participating provider:

- Check our provider directory, available online and at your request.
- Call Member Services.
- Visit our website at empireblue.com.

Requesting Approval for Benefits

Utilization Review

We review health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called Utilization Review (UR).

Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (Concurrent); or after the service is performed (Retrospective).

All determinations that services are not medically necessary will be made by licensed physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care provider who typically manages your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not medically necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, you can contact us or visit our website at empireblue.com.

Preauthorization Reviews

If Empire has all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request.

If Empire needs additional information, we will request it within 3 business days. You or your provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if Empire has all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. Empire will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and your provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

Concurrent Reviews

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all necessary information. If Empire needs additional information, we will request it within one business day. You or

your provider will then have 45 calendar days to submit the information. Empire will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business of our receipt of the information or, if we do not receive the information, within 15 calendar days of the end of the 45-day time period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you and your provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

Retrospective Reviews

If Empire has all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45 day period.

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

Retrospective Review of Preauthorized Services

Empire may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Utilization Review Internal Appeals

Members may request an internal appeal of an adverse determination, either by phone, in person, or in writing. You also have the right to appeal the denial of a Preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a non-participating provider, but only when the service is not available from a participating provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a participating provider, even if the non-participating provider has more experience in diagnosing or treating your condition. (This type of appeal will be treated as a grievance.) You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

Standard Appeal: If your appeal relates to a Preauthorization request, We will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request. If your appeal relates to a retrospective claim, We will decide the appeal within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Expedited Appeals: Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews. For expedited appeals, Your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours from receipt of the appeal or two business days of receipt of the information necessary to conduct the appeal.

Our failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal or within two business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

External Appeal

In some cases, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that a service does not meet our requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, you may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a covered service under the contract and
- In general, you must have received a final adverse determination through our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through our internal appeal process if:
  - We agree in writing to waive the internal appeal; or
  - We are not required to agree to your request to waive the internal appeal; or
  - You file an external appeal at the same time as you apply for an expedited internal appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause ordue to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

Your Right to Appeal a Determination that a Service is not Medically Necessary: If we have denied coverage on the basis that the service does not meet our requirements for medical necessity, you may appeal to an external appeal agent if you meet the requirements for an external appeal above.

Your right to Appeal a Determination that a Service is Experimental or Investigational: If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal above and your attending physician must provide additional information and the service, procedure or treatment recommended by your doctor must meet certain criteria.

Your Right to Appeal a Determination that a Service is Out-of-Network: If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an external appeal agent if you meet the two requirements for an external appeal above, and you have requested preauthorization for the out-of-network treatment. In addition, your attending physician must provide certain certifications and information. You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

External Appeal Process: You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal. Please see your policy for additional details about the external appeal application and documentation process, response timeframes and other details.

Exclusions

This list includes some of the more common services not covered by these plans:

- Benefits covered by Medicare or a governmental program
- Convalescent and custodial care
- Cosmetic services except as stated in your Contract
- Coverage outside of the United States, Canada or Mexico
- Dental services except as stated in your Contract
- Experimental or investigative treatment
- Felony participation - resulting in your participation in a felony, riot or insurrection
- Foot care
- Government facility - treatment provided in a hospital owned or operated by the federal, state or other government entity
- Not medically necessary
- Medicare or other government program
- Military service
- No-fault automobile insurance
- Services separately billed by hospital employees
- Services provided by a family member
- Services with no charge
- Services not listed in your Contract
- Vision services except as stated in your Contract

- Workers' compensation
- War-illness, treatment or medical condition due to war, declared or undeclared

Benefit Limits

Covered services may be subject to limits as described in the Benefit Contract, including without limitation:

- Autism – 680 hours per plan year
- Hearing aids – limited to a single purchase (including repair/replacement) every three years
- Home health care - 40 visits per plan year
- Hospice – 210 days per plan year, inpatient and outpatient combined
- Prosthetic device – 1 external prosthetic device per limb per lifetime (limit does not apply to internal devices)
- Skilled nursing facility – 200 days per plan year
- Therapy services – 60 visits per condition, per lifetime combined
  - Physical therapy
  - Occupational therapy
  - Speech therapy

This document is only a brief summary of benefits and services. Consult the Evidence of Coverage for complete coverage details including important exclusions, limitations and terms. You may also:

- Check the benefit certificate and any riders to the policy for complete coverage terms and conditions.
- Call your Empire authorized representative.
- Go to empireblue.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

*All plans, except Child Only plans, are available with optional coverage for dependents through age 29 and for additional skilled nursing facility coverage. If you would like to include this coverage, please be sure to choose a plan that includes the words “dependent age 29” or "SNF" in the plan name on the application.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Empire authorized representative to request them.