Empire BlueCross BlueShield

Individual and family health care plans
for **New York**

Our plans are designed to fit your plans

TraditionPLUS℠ hospital program

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Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. Health care coverage not only helps you stay healthy. It also gives you peace of mind because you know you have help with any unexpected health care bills.

You can't predict the future. But at least you can prepare for it.

In a world that's always changing, one thing's certain: it's important to have health care coverage you can depend on – coverage designed to fit different budgets and lifestyles. For over 75 years, Empire BlueCross BlueShield has provided health care coverage to our New York neighbors.

You're in charge of your health and budget. Our Individual health care plans help keep it that way. And if you have any questions, we're here to help.

Sounds like a plan.

Experience you can rely on

Empire BlueCross BlueShield is committed to helping improve your health. And simplifying your life. You can manage your health care coverage in a simple and easy way at empireblue.com. Once you're a member, all you have to do is register at empireblue.com and start feeling better about your choices.

- **Find a Doctor**: Use our online Provider Directory to find hospitals and other facilities in your area and check whether they are cost-saving network providers, all at the click of a mouse.
- **Care Comparison**: Save time and money by comparing the quality and safety of providers as well as the cost of common procedures at health care facilities in your area.
- **Zagat Health Surveys**: See what other patients have said about the hospitals you're considering. Add your own recommendation, too!

Register at empireblue.com and have a wealth of health information right at your fingertips.

Coverage you can count on.

Being ready for anything is the main reason you want the right health coverage. Especially when it comes to accidents and emergencies. That's why the TraditionPLUS hospital plan offers:

- Coverage for 100% of services performed in, and billed by, hospitals, ambulatory surgical centers and more.
- Coverage that begins on day one with no qualifying medical questionnaire to fill out.
- Coverage that goes where you go. No matter where life takes you, your health coverage goes with you. And the Blue Cross and Blue Shield Association's BlueCard® program makes it easy to access providers throughout the country.
- Coverage is available for your spouse and covered dependents under age 30.

Hospital services and medical services aren't the same thing. TraditionPLUS only covers hospital services.

Hospital services vs. medical services.

Hospital services are any covered services given and billed by hospitals or ambulatory surgical centers.

- The services can be on either an inpatient or outpatient basis and must be given for the treatment of an illness or an injury.
- Hospital services include, but are not limited to, inpatient room-and-board charges, operating room, delivery room and emergency room charges. They also include radiology and pathology charges for the use of the hospital's X-ray and laboratory equipment.
- Hospital or facility services do not include any charges billed by or in support of independent physicians, even if the physician's services are given during a hospital visit.

Medical services are any covered services given and billed by independent physicians, pharmacies and laboratories, no matter where the treatment was given.

- Medical services include, but are not limited to, physician's charges for surgery, anesthesiology and the charges for performing, reading, and interpreting X-rays and lab tests.
- They don't include any charges billed by (or for) hospitals, ambulatory surgical centers or any type of institutional facilities unless the medical provider is an employee of the hospital and the hospital bills for their services. Medical services given by independent physicians are not included in hospital charges and are not covered under your TraditionPLUS Hospital program. This does not apply to preventive care services which are covered 100% under TraditionPLUS.

TraditionPLUS℠

Is this the right plan for you?

Peace of mind is making sure you have the health benefits coverage you need at a price you can afford. That's where TraditionPLUS comes in.

TraditionPLUS plan highlights

The TraditionPLUS plan offers an affordable hospital plan with full coverage for preventive benefits.

Features:

- Coverage for services performed in, and billed by, hospitals and ambulatory surgical centers.
- Preventive care benefits that help you focus on staying healthy.

What you should know.

- Our TraditionPLUS hospital program covers services performed in (and billed by) hospitals or ambulatory surgical centers.
- Except for preventive care, TraditionPLUS does not cover medical services from physicians.
- For your hospital-related doctors fees to be covered, the physicians treating you must be employed by the hospital and cannot send you a separate bill for their services.
- Prescription drugs are not covered under the TraditionPLUS plan except as provided under preventive care for women's preventive care services.

Real value in a hospital program.

You'll get 365 days of paid-in-full inpatient hospital protection:

- Semiprivate rooms and board (paid in full in network or participating hospitals)
- Full range of hospital services, facilities, equipment and supplies
- Maternity care in birthing centers or hospitals
- Hospital care for newborns, up to 30 days
- Inpatient physical therapy and rehabilitation, up to 30 days
- In-hospital mental and nervous care, up to 30 days

Outpatient benefits let you get the specialized services you need:

- Emergency care for sudden, serious illness or accidental injury
- Ambulatory surgery (in approved ambulatory surgery centers or hospitals)
- Chemotherapy
- Radiation therapy
- Physical therapy – up to 90 visits per year after surgery or hospitalization
- Kidney dialysis – in a hospital, a free-standing facility or at home

TraditionPLUS℠ Hospital Program

- No deductible or copay
- No lifetime maximum
- No qualifying medical questionnaire to complete
- In-network benefits covered 100%

Benefits	TraditionPLUS℠ hospital program
Inpatient services	
Hospital coinsurance/ deductible	None
Inpatient Days - room and board	**Plan pays 100%**: Up to 365 days.
Outpatient hospital services	**Plan pays 100%**
Ambulatory surgery centers	**Plan pays 100%**
Skilled nursing facility (SNF)	**Plan pays 100%**: Up to 365 days if services are preapproved for admissions within 10 days of hospital discharge.
Other services	
Preventive care	**Plan pays 100%**: Includes preventive services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests and more.
Home healthcare (HH)	**Plan pays 100%**: Up to 200 visits. No prior hospitalization required.
Hospice care	**Plan pays 100%**: Up to 210 days
Inpatient mental health & substance abuse	**Plan pays 100%:** Up to 30 days in acute hospitals only.

Benefits described above apply when receiving care from a network provider.

Frequently asked questions

What if I have to go to an emergency room?

When emergency room services are given at your local network (or participating) hospital for the treatment of an accidental injury, your contract will cover the charges billed by the hospital in full. This would include the hospital's charge for the use of X-ray or lab equipment, the emergency room fee, and any medical services given by hospital employees. If you go to a non-network hospital you may be responsible for part of the bill.

You may receive separate bills from physicians who are not employed by the hospital. These separate provider bills may include charges from independent emergency room physicians as well as independent radiology and pathology providers. These providers may bill for services such as emergency room treatments (professional services) or interpretations of X-rays and lab tests. Even though these services are given in the hospital, they are considered medical services. Medical services are not eligible for benefits under your TraditionPLUS Hospital program.

When you are in the hospital, you should be sure to let the staff know that in order for all services to be covered, the services must be given by hospital employees. To find a local network hospital, go to empireblue.com > Find a doctor > Empire's Local area medical network > Select Hospitals and facilities then complete the information for the area you would like to search.

If you are admitted to the hospital right after treatment in the emergency room, you must let us know within two business days after you have been admitted to get inpatient coverage.

What if I need surgery?

When surgical services are given either on an inpatient or outpatient basis at your local network hospital, your contract will cover the facility charges in full. The surgical charges include the hospital's fee for the operating room, surgical equipment, fees for the use of any other hospital equipment and any medical services rendered by hospital employees.

When you're in the hospital for surgery, the separate charges for services given by physicians not employed by the hospital, such as the surgeon or anesthesiologist are not covered. This is because they are considered medical services. Medical services are not eligible for benefits under this hospital program.

Being prepared is one of the most important things about health benefits coverage.

Individual health coverage. Your plans. Your choices.

Sign up for our easy, no hassle payment option

We make it easy for you to make your monthly premium payments.

Through our Electronic Fund Transfer (EFT) program, we automatically withdraw funds from your bank account each month for the required premium amount. No check writing. No postage costs. No coverage lapse because you forgot to mail the payment. See ... we said we make it easy.

Sound good? Then complete the bank draft application included with your enrollment information.

Get a free look with a money-back guarantee!

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 are not fully satisfied, you may cancel your policy and your premiums will be refunded, less any claims that were already paid.

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Individual and family health care plans
for **New York**

Make sure you have all the facts.

After 9/23/12, to view a Summary of Benefits and Coverage please visit www.healthcare.gov.

This brochure is only one piece of information about your plan. Please make sure you have all the facts about the benefits offered by the plans you're considering – including what's covered, and what isn't. This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent, Empire, or visit us on the web. You may also see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Empire sales representative or agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract. If there is any difference between this brochure and your Contract, the provisions of the Contract will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Ready to enroll?

If you're ready to enroll or would like more information, we're ready to help! Call your Empire agent.

New York coverage details

Things you need to know before you buy...

Empire BlueCross BlueShield

TraditionPLUS, HMO and HMO POS

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

Waiting periods

For applicants age nineteen and older all Empire BlueCross and BlueShield contracts require an 11-month waiting period (12 months for HMO POS plans) for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within the six-month period ending on your enrollment date. We will credit the time you were previously covered under Creditable Coverage if the previous Creditable Coverage was continuous to a date not more than 63 days prior to your enrollment date.

Summary of Limitations and Exclusions

The following limitations and exclusions will help you understand what your health care plan does not include.

TraditionPLUS

1. We will not pay for transplants of artificial or animal organs or parts of such organs
2. Our reimbursement for transplant services is secondary to any and all government or institutional sources of funding except Medicaid
3. Each calendar year you may receive up to thirty (30) days of hospital services for the diagnosis and treatment of mental and nervous disorders
4. Each calendar year you may receive benefits for up to a maximum of thirty (30) days of inpatient hospital service for physical medicine or rehabilitation
5. Procedures that are not of proven benefit or have not been recognized by the medical profession as appropriate for diagnosis or treatment and procedures which are obsolete
6. We will not cover an inpatient hospital stay or any part of it that is primarily for diagnosis
7. Cosmetic surgery
8. Services covered by workers' compensation, no-fault automobile insurance, the Longshoremen's and Harbor Workers' Compensation Act, Jones Act or similar law
9. Services provided in a government hospital or a public benefit corporation hospital, unless we have a Participating Agreement with the hospital
10. Non-acute or chronic hospital care
11. Services usually given without charge
12. Injury or illness received as a result of war, declared or undeclared, or any act of war
13. No benefits are provided for travel expenses, even if the doctor recommends it
14. Any amount that is more than a provider charged for covered care or that is more than the Maximum Allowed Amount
15. Prescription medication except as provided under preventive care for women's preventive care services or as stated for a hospital or facility under the contract.
16. Reversal of sterilization, in vitro fertilization, artificial insemination, or other forms of assisted reproductive technology
17. Your newborn child may receive routine hospital services during the mother's medically necessary and appropriate hospitalization which is directly related to the birth of the newborn. However, this benefit ends thirty (30) days from the date of birth.
18. Treatments, procedures, hospitalization, drugs, biological products or medical devices which are experimental or investigational

HMO, HMO POS

1. Medically unnecessary care
2. Services provided in a government hospital or a public benefit corporation hospital, unless we have a Participating Agreement with the hospital
3. Services covered by workers' compensation, no-fault automobile insurance, the Longshoremen's and Harbor Workers' Compensation Act, Jones Act or similar law
4. Free care; care provided by family members
5. Government programs
6. Custodial care
7. Unauthorized services. (PCP referral required except ob/gyn and emergency services)
8. Cosmetic surgery
9. Admission to a hospital before you become covered under this contract
10. Dental care
11. Eyeglasses and hearing aids
12. Correction of structural imbalance, distortion or subluxation.
13. Routine care of feet
14. Outpatient treatment of, or inpatient rehabilitation services for, alcoholism and substance abuse
15. Examinations required by a third party, such as your employer, school or camp
16. Services required for a condition arising out of: participation in a felony; suicide; attempted suicide; intentionally self-inflicted injury; or war or act of war
17. Sex changes

18. Reversal of sterilization
19. Assisted reproductive technology
20. Speech, occupational, hearing or vision therapies provided by a hospital
21. Treatments, procedures, hospitalization, drugs, biological products or medical devices which are experimental or investigational
22. Donor fees; transportation
23. Charges for services pursuant to a prohibited referral (physician owned ancillary services)
24. Appetite suppressants
25. Compounded prescription drugs with ingredients not requiring a prescription
26. Replacement drugs resulting from loss, theft or breakage
27. Medications for cosmetic purposes only
28. Devices of any type such as therapeutic devices, artificial appliances, hypodermic needles, syringes or similar devices except where specifically covered
29. Drugs identified in the Drug Formulary as being subject to a precertification requirement; and your physician does not obtain precertification from us
30. In addition, our HMO plans also exclude:
    — Care by nonparticipating providers
    — Care provided outside of the HMO service area (with the exception of emergency care and urgent care)

Important contract information

The benefits described are subject to Empire managed care benefits provisions and to the terms and limitations of your Empire BlueCross BlueShield contract. For certain services, benefits must be pre-authorized. This contract may limit the number of days, visits or dollar amounts to be reimbursed.

The TraditionPLUS Hospital program meets the minimum standards for basic hospital insurance as defined by the New York State Insurance Department. This contract does NOT provide basic medical or major medical insurance.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review/Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Prospective review requirements may include but are not limited to:

- inpatient hospitalizations.
- outpatient procedures.
- diagnostic procedures.
- therapy services.
- durable medical equipment.

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member-authorized representative) and takes place by telephone, electronically and/or onsite. Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed health care professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

Your Rights and Responsibilities

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

If you purchase individual direct pay coverage with assistance from one of our licensed sales associates ("Sales Associates"), we will compensate the Sales Associate who assists you with your purchase based upon certain considerations, including, among other items, customer satisfaction and successful sales. If you would like additional information regarding the compensation that Empire pays its Sales Associates, please ask the Sales Associate assisting you for details.