Empire BlueCross

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

Our plans are designed to fit your plans

Direct Pay HMO
Direct Pay HMO POS

NYBR12005XHM Rev. 7/12

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.

Our plans help fit the way you live

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 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 is committed to helping improve your health. And simplifying your life. That's why we offer:

- **A large provider network** – Choose from more than 66,000 providers and 200 hospitals in the area.[1]
- **A choice of plans designed to fit different budgets and lifestyles** – We have plans that meet a range of health coverage needs and budgets. No matter where you are in life.
- **Prescription drug coverage** – Choose from a large pharmacy network that includes major chains and independent pharmacies.

1 BCBSA Provider Data Counts, 2012.

Some definitions – so we're all on the same page

Network discounts: With Empire, you have access to one of the largest provider networks in New York. These network providers have agreed to accept lower costs for their covered services to our members. This helps reduce the overall cost of covered medical services, including your share of those costs.

Cost sharing: The costs of medical care can be staggering. Health care coverage from Empire can help protect you from these high costs. With most health care coverage, you pay a monthly premium. Then you share some of the costs of covered services with the company providing the coverage (such as Empire).

Deductible: The amount you pay each calendar year for covered services before your health care plan starts paying. There is no medical deductible with the Direct Pay HMO plan. With the Direct Pay HMO POS, the deductible only applies to services received outside the network.

Family deductible: Family plans have both an individual and a family deductible. Any combination of family members can meet or contribute toward the family deductible. However, no individual member can contribute more than his or her individual deductible. The family deductible applies to the Direct Pay HMO POS for services received outside of the network. This also applies to the prescription drug deductible. But the family deductible only applies to services received outside of the network.

Coinsurance: A percentage of the cost of covered services you will be responsible for.

Copay: The specific dollar amount you pay for a covered service.

Out-of-pocket maximum: The most you pay in a calendar year for covered services. Once you reach your maximum, the plan pays 100% for most services for the rest of the calendar year.

Family out-of-pocket maximum: Family plans have both an individual and a family out-of-pocket maximum. Any combination of family members can meet or contribute toward the family out-of-pocket maximum. However, no individual member can contribute more than his or her individual out-of-pocket maximum.

Balance billing: The difference between what a provider charges and what the health plan pays for a service. You may be responsible for this amount if you use a provider outside of the Empire network.

Prescription drugs: Medications prescribed by your doctor. Empire offers coverage for generic drugs and brand-name drugs that are on our formulary.

Brand-name drugs: Prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Generic drugs: Prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually lower. Generic drugs must, by law, contain the same active ingredients as their name-brand equivalent and have the same clinical benefit.

Formulary: A list of prescription drugs our health care plans cover. They may include generic, preferred, brand-name and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. Empire's formulary includes at least one drug from each class of medication. In order to ensure coverage for your medication, you must use one of the drugs included on the formulary.

Direct Pay plans

Your needs are unique. Our Direct Pay plans are designed to fit those unique needs. Both plans offer a large provider network and coverage for:

- Doctor's services
- Inpatient hospital services
- Outpatient hospital services
- Outpatient surgery
- Maternity care
- Basic and preventive care
- X-ray and labs
- Pharmacy
- Emergency room services at the nearest doctor or hospital (does not need to be in the network)

Direct Pay HMO

With our Direct Pay HMO you and each member of your family chooses a primary care physician (PCP). Your PCP provides basic and preventive care, gives you referrals if needed, keeps your medical history, and arranges special service — all within the network. With the HMO, you pay a copay for most covered services.

Features:

- No-cost preventive care visits make it easier to focus on your health.
- There's no limit to the number of doctor's-office visits you can make.
- You pay a copay for most covered services, making your costs more predictable.
- Maternity care is included at no extra cost.

You should know:

Direct Pay HMO includes coverage for network services only. If you want to be able to see a provider outside the network, consider the Direct Pay HMO POS.

Direct Pay HMO POS

The Direct Pay HMO POS works like an HMO, but with more flexibility. As with an HMO, you'll choose a PCP to manage your care. But, with this plan, you can also see a doctor or go to a hospital that's not in Empire's network.

Features:

- No-cost preventive care visits make it easier to focus on your health.
- There's no limit to the number of doctor's-office visits you can make.
- When you stay in the network, you pay a copay for most covered services, making your costs more predictable.
- Maternity care is included at no extra cost.
- You have the freedom to use providers outside the network.

You should know:

While you have the option to use providers outside the network, you will pay more for these services. Costs may be in the form of deductibles, coinsurance or balance billing.

Empire BlueCross

Benefit Guide for New York

	Direct Pay HMO	Direct Pay HMO POS	
	Network only	**Network**	**Non-network**
Deductible	The amount you pay each calendar year before your plan starts paying:		
Calendar-year deductible	None	None	$1,000
Family deductible	None	None	$2,000
Out-of-pocket maximums	The most you pay, per calendar year:		
Individual	$1,500	None	$3,000
Family	$3,000	None	$5,000
Lifetime maximum	None	None	None
Covered services	The amount you pay:		
Doctors' office visits	$15/visit	$10/visit	20% coinsurance*
X-ray and lab services	$15/visit	$10/visit	20% coinsurance*
Professional and diagnostic services	$15/visit	$10/visit	20% coinsurance*
Hospital/facility inpatient services	$500 (per admission)	No cost	20% coinsurance*
Hospital/facility outpatient services	$75/visit	No cost	20% coinsurance*
Emergency room services	$50/visit	$35/visit	$35/visit
Preventive care (includes preventive services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, and more.)	No cost	No cost	No cost
Maternity care Pre and post-natal care Delivery	 No cost 20% up to $200	 No cost $10	 20% coinsurance* 20% coinsurance*
Prescription drugs	Subject to $100 deductible per individual, per calendar year. $300 deductible per family, per calendar year.		
Retail — 34-day supply	$5 Generic $10 Brand name	$5 Generic $10 Brand name	Not covered
Mail order — 90-day supply	$10 Generic** $20 Brand name**	$10 Generic** $20 Brand name**	Not covered

* For HMO POS non-network services: Coinsurance applies after the deductible is met.
**Not subject to the deductible.

Choose your doctor and compare your health care costs at empireblue.com

Manage your health care 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 with features like:

- *Find a Doctor:* Use our online Provider Directory to find hospitals, pharmacies and other specialists 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 doctors and hospitals you're considering. Add your own doctor recommendation, too!

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

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.

Additional information

Considering a Direct Pay plan? You can apply online, by email, mail, fax or over the phone with a licensed agent. Go to empireblue.com for the details. Here's some more information to make it easy to enroll.

Enroll in the right plan for you

You can enroll if:

- You are between 18 and 65 years old.
- You are not eligible for Medicare by reason of age, or group health coverage.
- You live in New York State within our 28-county service area.

You select the type of coverage:

- Individual
  - You are single with no dependent children.
  - You are married, you do not have dependent children, and your spouse is covered by Medicare or another benefit plan that does not provide dependent coverage to you.
- Applicant/Spouse — You are married, and you do not have dependent children (to age 26).*
- Parent/Child(ren) — You are single, and you have one or more dependent children (to age 26).*
- Family — You are married and you have one or more dependent children (to age 26).*

Automatic premium payment saves time

Hate writing checks? After your first payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll save on postage.

And you won't have to worry about a lapse in coverage because you forgot to mail your payment. To sign up, just fill out the billing section of the enrollment application.

*Some dependent children age 26 through 29 are eligible, if the dependent meets certain requirements.

If you want more information, call your Empire agent.

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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 these plans. This includes knowing what's covered and what's not. These plans have exclusions, limitations and terms under which they may be continued or discontinued. For costs or complete detail of coverage you can call us or visit us on the web. Also look at the Coverage Details. This may be included in your information kit. If you printed this from your computer, it should be at the end of the document. If you don't have the Coverage Details, please contact us.

This brochure is a brief summary of benefits and services. It is not your Contract. If there are differences between this brochure and your Contract, the Contract will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements. This includes applicable provisions of the federal health care reform law. As we receive additional guidance and clarification on new health care reform laws, we will make the additional changes required by law.

New York coverage details

Things you need to know before you buy...

Empire BlueCross

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 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 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.