A Health Benefits Program for Hofstra University Post 65 Retiree

Health Plan

12/2022

Effective Date 1/1/2022

HOFSTRA UNIVERSITY

GROUP NUMBER: 720508-RETM

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STOP FRAUD

Empire BlueCross BlueShield welcomes your help in preventing health insurance fraud. Fraud costs Empire and its customers millions of dollars each year. If you are aware of any illegal activity involving Empire BlueCross BlueShield, please make a confidential call to this phone number during normal business hours:

INTEGRITY HOTLINE: 1-800-I-C-FRAUD (423-7283).

The benefits described in this booklet are subject to the terms, conditions, limitations, and exclusions of the contract issued by Empire BlueCross BlueShield to your group. If a difference exists between the information in this booklet and the actual contract, the contract governs. Please consult your group's contract for additional information.

MANAGE YOUR HEALTHCARE ONLINE

Register Today For Online Member Services

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

Plus much more.

Here's What You'll Need To Do

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

Assistance is a Click Away

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

- **Email**: You can e-mail us with a question 24 hours a day, 7 days a week, and a customer service representative will e-mail an answer back to you through your Message Center.

Collaboration: Our representative will call you while you are online and navigate the site along with you. We can even take control of your mouse, making it easier to answer your questions.
Call Back: You can request that a representative contact you with assistance.

Get Personalized Health Information – Including your Health IQ

Click on MY HEALTH from your secure homepage after you register to receive the following features:
Take the *Health IQ* test and compare your score to others in your age group
Find out how to improve your score – *and your health* – online
Find out how to take action against chronic and serious illnesses
Get health information for you and your family

Your Privacy Is Protected

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

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

BENEFITS SUMMARY

INDEMNITY	
COST SHARING	**Member Pays**
DEDUCTIBLE	$500/$1,000 *individual/family*
COINSURANCE	20%
ANNUAL OUT-OF-POCKET MAXIMUM (includes Deductible)	$4,000 Individual/Family
DEPENDENT CHILDREN	Dependent children to end of month to age 26
HOSPITAL BENEFITS	**Member Pays**
INPATIENT 180 days-semiprivate room and board	$0
MENTAL HEALTH No less than the total number of medically necessary days provided under the Plan for the same service, for treatment of a medical condition (two partial hospitalization visits equal one inpatient day)	$0
SUBSTANCE ABUSE AND DETOX No less than the total number of medically necessary days of detoxification, provided under the Plan for the same service, for treatment of a medical condition	$0
OUTPATIENT Pre-surgical testing	$0
EMERGENCY ROOM/FACILITY (Accidental injury or sudden & serious medical condition)	Coinsurance
OTHER FACILITY BENEFITS	**Member Pays**
HOME HEALTH CARE Up to 240 visits per calendar year	Deductible and Coinsurance
HOSPICE Up to 210 days per calendar year	$0
SKILLED NURSING FACILITY Up to 100 day visit maximum per calendar year	$0

INDEMNITY	
MEDICAL BENEFITS	**Member Pays**
HOME/OFFICE VISITS Physician and Specialist	Deductible and Coinsurance
DIAGNOSTIC SCREENING & MAMMOGRAPHY	Deductible and Coinsurance
ANESTHESIOLOGY	Deductible and Coinsurance
LAB & X-RAY (NON-ROUTINE)	Deductible and Coinsurance
OUTPATIENT MENTAL HEALTH No less than the total number of medically necessary outpatient visits, in office or facility, provided under the Plan for the same service, for treatment of a medical condition	Deductible and Coinsurance
PHYSICAL THERAPY Up to 30 visits maximum per calendar year	Deductible and Coinsurance
OCCUPATIONAL & SPEECH THERAPY Up to 30 visits maximum per calendar year	Deductible and Coinsurance
DURABLE MEDICAL EQUIPMENT	Deductible and Coinsurance
AMBULANCE	Deductible and Coinsurance
CHIROPRACTIC CARE Up to 20 visits maximum per calendar year	Deductible and Coinsurance

GENERAL INFORMATION

Introduction

The hospital and basic medical benefits is a group healthcare plan available to you through an insurance policy issued and underwritten by Empire BlueCross BlueShield.

This is <u>not</u> an insured benefit Plan. The benefits described in this benefit book or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Empire BlueCross BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

Eligibility

Benefits are available for services rendered on or after the effective date of your membership in this group. You may elect either individual or family membership.

Individual membership covers only you.

Family membership can cover:
you
your spouse (a partner to a marriage legally recognized in the jurisdiction in which it is performed)
dependent children - to the end of the month in which they reach age 26
dependent children unable to support themselves because of mental illness, developmental disability, mental retardation (all as defined in the mental hygiene law), or physical handicap provided the incapacitating condition started before the age at which dependent coverage would otherwise end, as noted above.
Surviving Spouse
Your same-sex domestic partner. Please check with your Benefits Administrator for more information.

Foster children are not covered.

Surviving Children are not covered.

Retirees are not allowed to add coverage for dependents (spouse, domestic partner, or children). Only dependents that were covered by the employee prior to retirement and continuously through retirement are eligible for coverage.

Eligibility Rules

Eligibility rules for active employees are outlined in Exhibit A.

Employees who have already retired are subject to the contribution and eligibility rules in effect at the time of their retirement as outlined in the applicable collective bargaining agreement or University policy.

Addendum to Plan

AMENDMENT AND TERMINATION

Hofstra University reserves the right, in its sole and absolute discretion, to amend, modify or terminate any of its benefit programs, in whole or in part, at any time and for any reason, with respect to active or retired participants who are or may become covered by the plans and their dependents. If the benefits program is modified or terminated, in whole or in part, the ability of employees and retirees to participate in the plans and/or to receive benefits from the plans, as well as the type and amount of benefits provided under the plans, may be modified or terminated.
All benefits provided under the benefit plans and the eligibility rules for active, former, retired or disabled participants and their dependents:
Are not guaranteed;
May be changed or discontinued by Hofstra University at any time, in its sole and absolute discretion; and
Are subject to the rules and regulations adopted by Hofstra University.
Under no circumstances will any person obtain a vested or non-forfeitable right to receive, directly or indirectly, any welfare or health benefits provided by Hofstra University.

PLAN INTERPRETATION

Hofstra University (and/or its duly authorized designee(s)), has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, and any other Plan documents, and to decide all matters (including legal and factual issues) arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, Hofstra University and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:
Take all actions and make all decisions (both factual and legal) with respect to the eligibility for, and the amount of, benefits payable under the Plan;
Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan;
Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet or other Plan documents;
Process and approve or deny benefit claims; and
Determine the standard of proof required in any case.
All determinations and interpretations made by Hofstra University and/or their duly authorized designee(s) shall be final and binding upon all Participants, beneficiaries and any other individuals claiming benefits under the Plan.

All of the above is subject to the terms of any Collective Bargaining Agreement, to the extent applicable.

Qualified Medical Child Support Order (QMCSO)

A court order, judgment or decree that:

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

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

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

Removing a Dependent

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

Getting divorced (Spousal coverage ends on the last day of the month following a divorce or annulment.) Having your children reach the age limit for coverage, cease to be dependent on you or get married.

Coverage must be applied for within 30 days of termination for one of the reasons described above.

COLLEGE STUDENT MEDICAL LEAVE

The plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless dependent coverage ends earlier under another plan provision, such as the parent's termination of employment or the child's age exceeding the plan's limit.

Medically necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a medically necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). [The plan must receive written certification from the child's physician confirming the serious illness or injury and the medical necessity of the leave or change in status.]

Coverage continues even if the plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a plan changes during the extended period of coverage.

DEPENDENT CHILDREN COVERED TO AGE 26

If Your Plan makes coverage of dependents available, this Rider applies to coverage of children as follows:

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

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

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

Our Role in Notifying You

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

Conformity with Law

Any term of this Booklet which is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.

If You Want More Information

At least once a year, Empire will send all members general descriptions of the reimbursement methodologies that Empire uses by individual provider type.

In addition, you may request any of the following information about Empire:

The names, business addresses and official positions of Empire's Board of Directors, officers, controlling persons, owners and partners.
Empire's most recently published annual financial statement.
A sample of Empire's direct payment contracts.
A consumer report regarding grievances filed with the Insurance Superintendent.
Procedures Empire has established to protect confidentiality of medical records and other member information
A description of Empire's quality assurance program.
A notice of specific individual provider affiliations with participating hospitals.
Upon written request, specific written clinical review criteria for determining medical necessity.

For Members Who Do Not Speak English

Empire can help members who speak languages other than English ask questions and file appeals in their first language. When a Member Services representative receives a call from someone who speaks a language other than English, the representative puts the caller on hold and calls the AT&T Language Line. The AT&T Language Line operator links the Member Representative and the caller to an interpreter in the appropriate language. Through a three-way connection, the interpreter facilitates the inquiry or appeal.

Empire's application forms allow members to indicate if their primary language is other than English. Empire tracks this information, and when enrollment of non-English speaking members reaches a significant level, Empire develops member materials in that language.

HOSPITAL BENEFITS

Inpatient Days of Care

You are covered in full for 180 days a year, subject to any limitations and exclusions described.

Semiprivate Accommodations

If you are a hospital patient in a semiprivate room, your bed, board (including special diets), and general nursing care are covered in full for 180 days a year.

Private Accommodations

If you occupy a private room, you receive for the 180-day period a daily allowance equal to the hospital's average semiprivate room charge toward the cost of bed, board, and general nursing care.

Other Hospital Services

You are covered for the following services, regardless of the class of accommodations occupied, if they are necessary for the diagnosis and treatment of the condition for which you are hospitalized:

Use of operating and recovery rooms and equipment.
Use of intensive care or special care units and equipment.
X-ray, laboratory and pathological examinations.
Use of cardiographic or endoscopic equipment and supplies.
Drugs and medicines for use in the hospital which are commercially available for purchase and readily obtainable by the hospital.
Blood, use of blood transfusion equipment and administration of blood or blood derivatives when given by a hospital employee.
Sera, biologicals, vaccines and intravenous preparations.
Anesthesia supplies and use of anesthesia equipment.

Oxygen and other inhalation therapeutic services and supplies.
Dressings and plaster casts.
Physical and occupational therapy and rehabilitation services and supplies.
Radiation and nuclear therapy in a facility approved by the appropriate governmental authorities.
Any additional medical services and supplies customarily provided by Participating Hospitals unless specifically excluded from the contract.

Maternity Care

If the mother decides to be discharged earlier than either 48 hours after childbirth for any delivery other than a caesarean section or 96 hours following a caesarean section she shall be entitled, upon request made within that time period, to one home care visit. This visit shall be delivered within 24 hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits of this plan. In addition, this home care visit is not subject to the deductible or coinsurance.

Maternity care coverage also includes, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

Newborns' and Mothers' Health Protection Act of 1996

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

Inpatient Mastectomy Stays

Inpatient hospital care includes coverage for an inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of the stay will be determined by you and your doctor.

Emergency Services

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

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

Serious impairment to such person's bodily functions;

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

Serious disfigurement of such person.

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

Emergency Services are not subject to prior authorization requirements.

To prevent your having to pay unnecessary charges and at the same time to get the care you need when you need it, just follow the simple instructions below.

What to Do in an Emergency

If you have questions about a health situation and/or emergencies, you should call your personal physician for advice. Your personal physician will direct you to the appropriate care setting.

Call an ambulance or go directly to an emergency room if you cannot call your personal physician in advance. If possible, go to the emergency room of the hospital where your personal physician is affiliated.

Emergency Care Outside Our Service Area

If you have a medical emergency while you are away from home and outside our service area (28 counties in New York State), follow Steps 1 and 2 above.

If you must go to an emergency room, show your member ID card at the hospital. If the hospital participates with another Blue Cross and Blue Shield plan, that plan will submit your claim to Empire.

Presurgical Testing

You are covered for diagnostic tests performed in a hospital if the tests are prescribed by your doctor and are preliminary to scheduled surgery in the same hospital.

Your health plan also covers the following services:

Chemotherapy

Benefits are available for unlimited cancer chemotherapy treatments (including medications) when provided in a hospital on an outpatient basis.

Mammography Screening

Mammography screenings are covered if requested by a doctor and indicated by the patient's health history. In addition, annual mammography screenings are covered for women 35 years of age or older.

Cervical Cytology Screening

Cytology screening benefits are provided for women 18 years of age and older for one routine pelvic examination per calendar year, including Pap smear and diagnostic evaluation of the Pap smear. These services must be given by a hospital employee and billed by the hospital.

Physical Therapy, Physical Medicine and Rehabilitation

Room and board are covered in participating hospitals for up to **100** days each calendar year for stays or portions of stays primarily for physical therapy, physical medicine, and rehabilitation combined for hospital, skilled nursing facility or rehabilitation facility.

Dialysis for Kidney Failure

Your health plan covers hemodialysis or peritoneal dialysis while the covered individual is a registered bed patient in a hospital. Outpatient dialysis benefits are also available, as follows:

In the home - Empire will pay the cost of all appropriate and necessary supplies required for home dialysis treatment, as well as the reasonable rental cost of the required equipment.

In a hospital or freestanding facility - Empire will pay the cost of necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

These dialysis benefits will be available until the patient becomes eligible for coverage under Medicare.

Mental Health Care

Hospital benefits for inpatient mental health care are provided for no less than the total number of medically necessary days (two partial hospitalization visits equal one inpatient day) provided under the Plan for the same service, for treatment of a medical condition, when hospitalized in:

- Participating Hospitals or non-governmental general hospitals located outside our Plan area;
- Hospitals that have a special agreement with the Plan to provide this care, including:
  - ⇒ General hospitals of the New York City Health and Hospitals Corporation;
  - ⇒ Non-governmental psychiatric hospitals which have a special agreement with the Plan to provide this care;
  - ⇒ General hospitals operated by counties within or immediately adjacent to the Plan's operating area.

Hospital benefits are provided for outpatient mental health care visits in a facility-based program, for no less than the total number of medically necessary visits provided under the Plan for the same service, for treatment of a medical condition.

We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges.

Outpatient Alcoholism and/or Substance Abuse Treatment

Outpatient benefits for the diagnosis and treatment of alcoholism and/or substance abuse are available to each covered person and may be used in any combination for no less than the total number of medically necessary visits provided under the Plan for the same service, for treatment of a medical condition. Some of these visits may be used for family counseling, even if the patient's treatment has not yet begun. Medically necessary family counseling is available to all persons covered under the patient's family contract.

Within New York State, the program covers alcohol or substance abuse when treated at facilities certified by the New York State Division of Alcoholism and Substance Abuse Services.

Outside New York State, the program covers alcohol or substance abuse treatment at facilities with a treatment program approved by the Joint Commission on Accreditation of Health Organizations.

Clinical Trials

We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:
Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and

Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this booklet.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this benefit plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

A federally funded or approved trial;

Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or

A drug trial that is exempt from having to make an investigational new drug application.

HOME CARE BENEFITS

Home Care benefits are available under a physician-approved plan of treatment. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required.

Covered services include: part-time professional nursing; part-time home health aide services (up to four hours of such care is equal to one home care visit); physical, occupational, or speech therapy; medical supplies, drugs, and medicines prescribed by a physician; and necessary laboratory services.

Additional services are available when home care if care begins within seven days of discharge from a hospital: medical social work visits; X-ray and EKG services; ambulance or ambulette to the hospital for needed care up to **240** home care visits per calendar year.

HOSPICE BENEFITS

The covered person has coverage for up to **210** days of hospice care may take place in a hospice, a hospital, at home or in an outpatient facility. Hospice benefits apply if the covered person has been certified by his or her primary attending physician as having a life expectancy of twelve (12) months or less. In addition, the following applies:

the hospice is both located in New York State and is certified pursuant to Article 40 of the New York Public Health Law, or

the hospice is located outside of New York State and is certified by the state in which the hospice organization is located.

Typically, covered hospice and outpatient services include:

Bed patient care, either in a designated hospice unit or in a regular hospital bed, and day care services provided by the hospice organization.

Home care and outpatient services provided by the hospice and charged to you by the hospice are also covered. The services may include the following:

Intermittent care by a RN, LPN, or Home Health Aide.
Physical therapy.
Speech therapy.
Occupational therapy.
Respiratory therapy.
Social services.
Nutritional services.
Laboratory examinations, X-rays, chemotherapy, and radiation therapy when required for control of symptoms.
Medical supplies.
Drugs and medications prescribed by a physician and which are considered approved under the *U.S. Pharmacopoeia* and/or *National Formulary* (not covered when the drug or medication is of an experimental nature).
Medical care provided by the hospice physician.
Five visits for bereavement counseling for the covered persons' family, either before or after the covered person's death.
Durable medical equipment (rental only).
Transportation between home and hospital or hospice organization when medically necessary.

HOSPITAL LIMITATIONS AND EXCLUSIONS

Hospital benefits are not provided for the following:

Services that in our judgment are not needed for your proper medical care or treatment. If services are rendered which cost more than other modalities of care, which are equally or more beneficial, benefits may be limited to the costs of the less expensive modality or treatment. All or any part of a hospital stay related to an unnecessary service is excluded.

Confinements for sanitarium-type, custodial or convalescent care, rest cures or care in a hospital, or a separate division of the hospital, where half the days of care provided by the hospital are part of stays more than 90 days in length.

Hospital confinements or any period of hospital confinement primarily for diagnostic studies, unless such studies are performed in connection with specific symptoms and not part of a general physical examination or check-up.

Services for which benefits are available under a Workers' Compensation law or similar legislation or military service-related care in a veterans' facility or a hospital operated by the United States.

Any services which mandatory automobile no-fault benefits are recovered or recoverable.

Active employees or their spouses, however, if neither you nor your spouse is an active employee, these benefits will be reduced by the amount received from Medicare for the same services.

Referrals for pharmacy services, clinical laboratory, X-ray or imaging services by physicians or other health care practitioners to facilities in which they or an immediate family member have a financial interest or relationship, as prohibited by the New York Public Health Law.

Services covered under federal or state government programs (except Medicaid).

Technology including treatments, procedures, drugs, biologicals, or medical devices which, in our sole discretion, are not medically necessary in that they are

experimental or investigational
obsolete or ineffective,

nor any hospitalization in connection with such technology.

"Experimental" or "investigational" means that the technology is:

not of proven benefit for either the particular diagnosis or treatment of the covered person's condition, **or** not generally recognized by the medical community (as reflected in the published peer-reviewed medical literature) as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit nor appropriate or effective for a particular diagnosis or treatment of a covered person's particular condition.

We may apply any or all of the following five criteria in determining whether a technology is experimental or investigative, obsolete, or ineffective:

Medical device, drug, or biological product must have received **final** approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for **another** diagnosis or condition may require that any or all of these five criteria be met.
Conclusive evidence (from the published peer-reviewed medical literature) must exist that the technology has a definite positive effect on health outcomes.
Demonstrated evidence (as reflected in the published peer-reviewed medical literature) must exist that over time the technology leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
Proof (as reflected in the published peer-reviewed medical literature) must exist that the technology is at least effective in improving health outcomes, or is usable in appropriate clinical contexts in which established technology is not employable.
Proof (as reflected in the published peer-reviewed medical literature) must exist that improvement in health outcomes (as defined in #3 above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

Surgery and/or treatment for gender change that does not meet our medical criteria for medical necessity.

Limitation For Pre-existing Conditions

A pre-existing condition is any disease, ailment, or condition for which you received medical or surgical treatment or advice within six months prior to the date that coverage began. It is also any disease, ailment, or condition which produced symptoms within six months prior to the date that coverage began which would have caused an ordinarily prudent person to seek medical or surgical treatment or advice, even though you did not seek treatment or advice.

A pregnancy existing on the effective date of coverage is a pre-existing condition. We will not pay for any pre-existing condition or any complications of a pre-existing condition, which happened after you became covered until you have been continuously covered under this plan for 11 consecutive months.

Certificates of Creditable Coverage After Termination

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of coverage must be issued to a Member and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable Coverage will include the names of any Members terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group and/or when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members within a reasonable amount of time after Empire has terminated membership. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

SECOND SURGICAL OPINION

A free second surgical opinion for elective surgery is available to employees and their dependents who are covered under our Program.

You may be hesitant when a surgeon recommends elective surgery (surgery that is not performed as an emergency). If you wish to have a second opinion as to whether surgery is the most appropriate course of action, call Empire BlueCross BlueShield's Second Opinion Referral Center at **1-800-249-8060**. The Center will provide you with names of three qualified surgeons who specialize in the field for which surgery is recommended. You select one of the three and make an appointment. The second opinion and the Allowed Amount for any X-rays or laboratory tests required are provided at no cost to you. The surgical specialist rendering the second opinion will not perform the surgery or otherwise treat you.

If the surgical specialist does not confirm the need for surgery, and you are still in doubt, you may request a third opinion consultation.

You make the final decision whether to undergo the operation or proceed with an alternate treatment.

PREVENTIVE SERVICES

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services other than preventive care for chronic conditions described in Paragraph I below are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at *www.empireblue.com* for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

1. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

2. **Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at *www.empireblue.com*, or will be mailed to You upon request.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

3. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:
   - One (1) baseline screening mammogram for Members age 35 through 39;
   - Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
   - One (1) screening mammogram annually for Members age 40 and over.

   If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

4. **Family Planning and Reproductive Health Services.** We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Rider for Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

   We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

   We do not Cover services related to the reversal of elective sterilizations.

5. **Bone Mineral Density Measurements or Testing.** We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Rider for Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:
   - Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
   - With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
   - On a prescribed drug regimen posing a significant risk of osteoporosis;
   - With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
   - With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

   We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

6. **Screening for Prostate Cancer.** We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

WELLNESS BENEFITS

A. Purpose. The purpose of Our wellness program(s) is to encourage You to take a more active role in managing Your health and well-being. Our wellness-related programs are designed to help You achieve Your best health. These programs are not Covered services under Your Plan, but are separate components which are not guaranteed under Your Plan and could be discontinued at any time. Participation is voluntary, and You may elect to no longer participate at any time.

B. Description. We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

1. **Health Assessment Completion.** A Health Assessment is an online health tool. You will answer questions about Your lifestyle, current health and history. You will have access to a personal report with health tips and available online programs.
    - **Eligibility.** The Subscriber and the Subscriber's covered Spouse age 18 and older can participate in the program and are eligible for rewards. Other covered dependents can participate in the program but are not eligible for rewards.
    - **Participation.** To access the Health Assessment, register or log in to Our website at *www.empireblue.com*. If You haven't set up a user name and password, select Register Now to set them up. Then click on the Health & Wellness tab and select "Take my HA now" to complete the assessment. On Your first visit to the site, You'll be asked to give Your email address and choose health topics of interest. If You do not have access to a computer, please call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access. We will provide You with a paper Health Assessment that will allow You to participate without computer access.

2. **Future Moms.** Future Moms is a maternity management program which provides individualized support to expectant moms to help them achieve healthier pregnancies and deliveries. The program provides education and support for high-risk and non-high-risk expectant mothers.
    - **Eligibility.** The Subscriber and the Subscriber's covered Spouse age 18 and older can participate in the program and are eligible for rewards. Other covered dependents can participate in the program but are not eligible for rewards.
    - **Participation.** Expectant moms can sign up and enroll by calling Us toll free at 800-828-5891. A member of Our Future Moms team will help You get started.

3. **ConditionCare.** The ConditionCare program provides access to education and goal-oriented health coaching from Our clinical team. The conditions included in the ConditionCare program are coronary heart disease, heart failure, diabetes, asthma and chronic obstructive pulmonary disease (COPD).
    - **Eligibility.** The Subscriber and the Subscriber's covered Spouse age 18 and older can participate in the program and are eligible for rewards. Other covered dependents can participate in the diabetes and asthma programs but are not eligible for rewards.
    - **Participation**. Eligible members can participate in one (1) program per year. You can self-enroll in ConditionCare if You've been diagnosed with one of the given conditions listed above by calling Us toll free at 866-962-0951. One of Our nurse care managers will help You get started.

COORDINATION OF BENEFITS

Occasionally, individuals have health care coverage under two programs. When this happens, the two programs will coordinate their benefit payments so that the combined payments do not exceed the actual expenses incurred.

Our Coordination of Benefits Program establishes which health coverage program has primary responsibility. The primary health coverage program will reimburse you first. When this contract is secondary, the total benefits paid by Empire will not exceed the amount Empire would have paid if this contract were primary.

To determine primary and secondary coverage, we use the following criteria:

The health coverage program without a coordination of benefits provision similar to this one will have primary responsibility.

The health coverage program listing the patient as the employee (rather than a dependent) will have primary responsibility.

A dependent child covered under both parents' health coverage programs will receive coverage as follows:

the program of the parent having his or her birthday earlier in the calendar year (only month and day are considered) will have primary responsibility
if the parents have the same birthday the health coverage program covering the parent longer will have primary responsibility
if the other health coverage program does not have a "birthday" provision and uses gender to determine primary responsibility the father's health coverage program will have primary responsibility.

A dependent child covered either by divorced or separated parents who have no court decree of financial responsibility for the child's health care expenses, will receive primary coverage under the custodial parent's health care program.

If the parent with custody remarries, we use the following order to determine primary responsibility:

the program of the parent with legal custody
the stepparent's program
the program of the parent without legal custody.

A dependent child covered by either divorced or separated parents who have a court decree specifying which parent has financial responsibility for the child's health care expenses will have primary coverage under that parent's contract if that parent's contract has actual knowledge of that decree.

If the patient is both covered as an active employee or as a dependent of an active employee and has coverage under another health care program as either a laid-off employee, a retired employee, or a dependent, then the active employee's health coverage program will have primary responsibility. However, if the other health coverage program does not have this rule and the two contracts do not agree on which coverage has primary responsibility, then this rule will not apply.

If none of the previous rules apply, the health program that has covered the patient the longest will have primary responsibility.

Carve-out Program

Carve-out is a program for subscribers who are eligible for Medicare. You will receive the same benefits as the non-Medicare members in your group. You or your health care provider should file a claim with Medicare, not Empire. After Medicare processes your claim, forward it to Empire for additional processing.

As a Carve-out subscriber, you must meet the same contractual requirements (e.g., deductibles, coinsurance, maximum allowances, etc.) as non-Medicare eligible employees. You must also meet the Medicare Part B deductible. That deductible, however, is automatically subtracted from any applicable Empire deductible. Therefore, you pay the same total deductible as your non-Medicare eligible colleagues.

Carve-out will not pay for a service that is not covered by your group's plan.

HOW TO CLAIM BENEFITS

You must file a completed health insurance claim form (and any other supportive materials) within 12 months of the service date to receive reimbursement. Empire can only process claims submitted either in English or with an English translation. To protect you from unnecessary costs resulting from fraud and abuse, **we will only consider original bills or receipts** with your claim form. **Photocopies are not acceptable.** Please keep photocopies of the documents you send us since we cannot return the originals.

Hospital Claims

Empire BlueCross BlueShield usually receives claims directly from participating hospitals/facilities. If the participating hospital or other facility does not submit a claim, however, you must send us the itemized hospital bill directly.

Inpatient Services

When admitted to a participating hospital as a registered inpatient, present your Empire BlueCross BlueShield identification card. The hospital will bill us directly and we will pay the hospital.

Outpatient Services

When treated in a participating hospital's outpatient department or emergency room, present your Empire BlueCross BlueShield identification card. The hospital will bill us directly and we will pay the hospital.

For either out-of-area or non-participating hospitals, you may have to pay the hospital's bill. When this happens, obtain an itemized hospital bill with the following information:

Patient's name and date of birth

Empire BlueCross BlueShield identification number

Subscriber's name and address

date of each service

charge for each service.

Send the itemized bill (and receipt, if you paid the bill) to:

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

Medical Claims

When you receive care from a doctor, he or she will send us the claim and we will pay either you or the provider. If we send the payment to the provider, we will also send you a notice describing the payment. To ensure valid reimbursement for the services you receive, submit your claims with an itemized bill, whenever possible.

The itemized bill should include the following information:

patient's name

complete service date (month, day, year)

diagnosis

description of service(s) performed

charge for each service

provider's complete name and address.

Also, please send us your claims as soon as possible after the service date.

Doctors' Services

You and/or the provider must complete a health insurance claim form. Before completing the form, be sure to read the instructions on the back. You must complete a separate claim form for each family member. Send the completed claim form with any supporting information to:

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

Other Services

To submit a claim for any of the services listed below, attach the provider's original itemized statement:

ambulance charges - Include the patient's full name and address, date of and reason for service, total mileage traveled, amount of charges, and a copy of the authorization for the ambulance.

supplies, durable medical equipment, and orthotic charges - Include a copy of the doctor's authorization, a description of the item, and an explanation of the item's medical necessity.

Medical Necessity

We Cover benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it. We may base Our decision on a review of:

Your medical records;
Our medical policies and clinical guidelines;
Medical opinions of a professional society, peer review committee or other groups of Physicians;
Reports in peer-reviewed medical literature;
Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
The opinion of Health Care Professionals in the generally-recognized health specialty involved;
The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
They are required for the direct care and treatment or management of that condition;
Your condition would be adversely affected if the services were not provided;
They are provided in accordance with generally accepted standards of medical practice;
They are not primarily for the convenience of You, Your family, or Your Provider;
They are not more costly than an alternative service of sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or infusion of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in the physician's office of the home setting.

How You Can Participate in Policy Development

Empire wants to hear from you if you have suggestions about how we can improve our products or our policies and procedures. You may call or write to Customer Service using the telephone number and address indicated on the back of your identification card. In addition, Empire regularly conducts customer satisfaction surveys that permit you to share your suggestions and opinions with us.

Fraud and Abusive Billing

We have processes to review claims before and after payment to detect fraud and abusive billing. In addition, We may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected for review under this program, then as part of the review process We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan may have the right to recover payments it makes on your behalf from a party responsible for compensating you for your illnesses or injuries, as permitted by applicable law. When a right to recovery exists, the following will apply:

The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery, as permitted by applicable law, in the amount of the benefits paid on your behalf and the following provisions will apply:

You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, as permitted by applicable law, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.

You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery, as permitted by applicable law. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
You fail to cooperate.
In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan, as permitted by applicable law.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, to the extent permitted by applicable law, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

The Plan is entitled to reimbursement from any Recovery, to the extent permitted by applicable law, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.

You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan, to the extent permitted by applicable law.

You must not do anything to prejudice the Plan's rights.

You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

CONSOLIDATED APPROPRIATIONS ACT OF 2021 NOTICE

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) pathology; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (I) Hospitalists; (J) Intensivists; and (K) any services set out by the U.S. Department of Health & Human Services. In addition, Empire will not apply this notice and consent process to you if Empire does not have an In-Network Provider in your area who can perform the services you require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Empire is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Empire that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount. In addition to your In-Network cost-shares, the Out-of-Network Provider can also charge you for the difference between the Maximum Allowed Amount and their billed charges.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Grievance Procedures"**]** section of this Benefit Book.

Transparency Requirements

Empire provides the following information on its website (i.e., *www.empireblue.com*):

- Protections with respect to Surprise Billing Claims by Providers;
- Estimates on what Out-of-Network Providers may charge for a particular service;
- Information on contacting state and federal agencies in case you believe a Provider has violated the No Surprise Billing Act's requirements.

Upon request, Empire will provide you with a paper copy of the type of information you request from the above list.

Empire, either through its price comparison tool on **[***www.empireblue.com***]** or through Member Services at the phone number on the back of you ID card, will allow you to get:

- Cost sharing information that you would be responsible for, for a service from a specific In-Network Provider;
- A list of all In-Network Providers;
- Cost sharing information on an Out-of-Network Provider's services based on Empire's reasonable estimate based on what Empire would pay an Out-of-Network Provider for the service.

In addition, Empire will provide access through its website to the following information:

- In-Network negotiated rates;
- Historical Out-of-Network rates; and
- Drug pricing information.

TERMINATION, CONVERSION, AND CONTINUATION OF COVERAGE

Termination of Coverage

Your coverage may terminate for any of the following reasons:

Empire terminates the contract

your employer terminates the contract

your employer fails to continue to meet our underwriting standards

your employer fails to pay premiums

you fail to pay premiums (if required)

either you or your covered dependents no longer meet either your employer's or the contract's eligibility requirements

you or your covered dependents have made a false statement on either an application for coverage or a health insurance claim form or have otherwise engaged in fraud

either you (as an active employee) or your covered dependents become Medicare eligible and elect Medicare as primary coverage or become Medicare eligible for reasons other than disability.

Conversion of Coverage

Under certain circumstances, you may convert your group coverage to individual coverage with comparable benefits if such coverage is available from your group Or, you may convert your group coverage to a Medicare supplement policy, if appropriate. However, not all your current benefits may be available when you convert your coverage. Please see your Benefits Administrator for details.

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

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

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

NOTICE OF QUALIFYING EVENTS:

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

For the other qualifying events, (your divorce or legal separation, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Plan Sponsor or the Group Benefits Administrator for your group.

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

any required premium is not paid in full on time,

a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,

a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or

the employer ceases to provide any group health plan for its employees.

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

If your qualifying event is the end of employment or reduction in hours of employment an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration, of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

DISABILITY

An 11-month extension of the maximum coverage period may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage. The disability has to have started at some time before the 60th day of

COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your plan administrator for additional information. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage (or during the first 29 months of continuation coverage, in the case of a disability extension). The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

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

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

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

FOR MORE INFORMATION

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

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration for your group.

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

The Veterans Benefits Improvement Act of 2004

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

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

Under State Law

If you are not entitled to continuation of coverage under COBRA, you may be entitled to continuation of coverage under the provisions of the New York State Insurance Law.

The provisions under State Law vary from those under COBRA, but both generally provide coverage for up to 18, 29, or 36 months. For example, continuation of coverage under State Law may be available if employment terminates due to gross misconduct. Under State Law, the first premium payment is due 60 days from the date of election to continue coverage. The premium may not exceed 102% of the actual group rate, even if the affected person is receiving coverage during the extension period due to a disability determination.

Under State Law, continued coverage is not available when the qualified person is covered, becomes covered, or could be covered under any type of group health coverage and such other group coverage does not contain any exclusion or limitation to any pre-existing condition, or the qualified person is covered, becomes covered, or could be covered by Medicare. Under State Law, reduction in the number of work hours is not a circumstance which allows continuation of coverage, but termination of membership in an eligible class is a triggering event.

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

Portability of Coverage

If you had similar coverage (hospital, medical, or major medical) from another insurance carrier within 63 days prior to the **effective date** of your Empire coverage, you will receive credit for whatever **waiting period** you met under that prior contract. To determine your **eligibility** for this portability of coverage, you must provide Empire with a letter of proof from the prior carrier or group that contains the covered person's name, contract type, start and end dates of coverage, and names of covered dependents.

We recommend that the evidence of prior coverage be submitted immediately to establish your **portability** and therefore, avoid possible claim rejections.

Remember, **portability** will only be established if you certify that no more than 63 days passed between the cancellation date of the former coverage and the **effective date** of your new coverage.

Disability and Continuation of Your Coverage

If you are totally disabled when coverage ends, coverage will continue for the disabled person for hospital stays beginning or surgery performed during the next 90 days for the injury, illness, or pregnancy which caused the total disability.

Coverage will end when:

you are no longer totally disabled, **or**

you have received the maximum benefits of the contract, **or**

you become eligible for total disability benefits under another group program, whichever comes first.

Carve-out Program

Carve-out is a program for subscribers who are eligible for Medicare. You will receive the same benefits as the non-Medicare members in your group. You or your health care provider should file a claim with Medicare, not Empire. After Medicare processes your claim, forward it to Empire for additional processing.

As a Carve-out subscriber, you must meet the same contractual requirements (e.g., deductibles, coinsurance, maximum allowances, etc.) as non-Medicare eligible employees. You must also meet the Medicare Part B deductible. That deductible, however, is automatically subtracted from any applicable Empire deductible. Therefore, you pay the same total deductible as your non-Medicare eligible colleagues.

Carve-out will not pay for a service that is not covered by your group's plan.

APPEALS AND GRIEVANCES

GRIEVANCE PROCEDURES

A. Grievances. Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

B. Filing a Grievance. You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.
We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 60 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	Call Customer Service Number

D. Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	30 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	60 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

UTILIZATION REVIEW

1. **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. 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). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

   All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

   We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card, or visit Our website at *www.empireblue.com*.

2. **Preauthorization Reviews.**

   a. **Non-Urgent Preauthorization Reviews.** If We have 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, in writing, within fifteen (15) calendar days of receipt of the request.

      If We need additional information, we will request it within fifteen (15) calendar 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, in writing, within fifteen (15) calendar days of Our receipt of the additional 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 allowed to submit the additional information.

   b. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

      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. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

   c. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, 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 notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

d. Crisis Stabilization Centers. Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your treatment.

3. Concurrent Reviews

1. Non-Urgent 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, in writing, within fifteen (15) calendar days of receipt of all necessary information.

If We need additional information, we will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

2. 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 (or Your designee) and Your Provider within 24 hours of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination. We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. 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. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

3. Inpatient Substance Use Disorder Treatment Reviews. If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

4. Retrospective Reviews. If We have 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 all or part of the requested 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.

5. Retrospective Review of Preauthorized Services. We 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.

6. **Reconsideration.** If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider and in writing.

7. **Utilization Review Internal Appeals.** You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

   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 which 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. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

   1. **Out-of-Network Service Denial.** 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. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
      - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
      - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

   2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
      - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
      - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

8. **First Level Appeal.**

   Preauthorization 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 (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

   Retrospective Appeal. 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 (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of a review 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, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external review.

Substance Use Appeal. If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external review within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external review is pending.

9. **Second Level Appeal.** If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external review. **The four (4) month timeframe for filing an external review begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file for external review.**

   A second level Appeal must be filed within 60 days of receipt of the final adverse determination on the first level 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 inform You, if necessary, of any additional information needed before a decision can be made.

   1. **Preauthorization 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 (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

   2. **Retrospective Appeal.** 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 (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

External Review

A. If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

B. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

C. All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act Of 1974 (ERISA)

If your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections under ERISA. Under ERISA you are entitled to:
Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor or Internal Revenue Service.
Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each covered member with a copy of this summary annual report.

Duties of The Plan Fiduciaries

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

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a covered member of the plan.
Under ERISA, you have the right to have your Plan Administrator review and reconsider your claim. If we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal our decision. You, or your authorized representative, may submit a written request for review. You have the right to obtain copies of documents relating to the decision without charge. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
If you submit a written request for copies of any plan documents or other plan information to which you are entitled under ERISA and you do not receive them within 30 days, you may bring a civil action in a federal court. The court may require the Plan Administrator to pay up to $110 for each day's delay until you receive the materials. This provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.

In the unlikely event that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. But if you lose, because, for example, the case is considered frivolous, you may have to pay all costs and fees.

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

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

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

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:

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.

INTER-PLAN PROGRAMS

BlueCard® Program. Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard® ~~BlueCard~~ Program, the amount You pay is calculated based on the lower of:

3. Negotiated (non-BlueCard Program) Arrangements. With respect to one or more Host Blues, instead of using the BlueCard® ~~BlueCard~~ Program, Empire may process Your claims for ~~covered~~ Covered ~~services~~ Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section 2. BlueCard® ~~BlueCard~~ Program) made available to Empire by the Host Plan.

4. Special Cases: Value-Based Programs. BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments. Additional information is available upon request.

Value Based Programs: Negotiated (non-BlueCard Program) Arrangements. If Empire has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on Your behalf, Empire will follow the same procedures for Value-Based Programs administration and care coordinator fees~~Care Coordinator Fees~~ as noted above for the BlueCard®~~BlueCard~~ Program.

6. Non-Participating Providers Outside Our Service Area.

a. Allowed Amounts and Member Liability Calculation. When Covered Services are provided outside of Empire's Service Area by Non-Participating Providers ~~non-participating providers~~, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the Non-Participating Provider ~~non-participating provider~~ bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

b. Exceptions. In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by Non-Participating Providers ~~non-participating providers~~. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider ~~non-participating provider~~ bills and the payment We make for the Covered Services as set forth in this paragraph.

EXHIBIT A

ADMINISTRATIVE EMPLOYEES

ACTIVE EMPLOYEES

Administrators must contribute 25% of the cost of the healthcare plan selected. Contributions are made on a pre-tax basis.

RETIREE BENEFITS
(Applicable to Administrators not yet retired)

Retirement healthcare benefits are currently available to full-time administrators employed by the University as a full-time administrator prior to September 1, 2003, and who have ten (10) years of full-time continuous service and who have reached age 60.

Effective January 1, 2015, retirement healthcare benefits for administrators who are eligible as defined above are available until the date that the retiree becomes eligible for Medicare. After the retiree's Medicare eligibility date, healthcare benefits will no longer be provided through the University.

For administrators employed as of September 1, 2003, healthcare retirement benefits (as described above) are provided on the following terms:

- If employed for more than ten (10) years as of September 1, 2003, and you become eligible for retirement, upon your retirement you and your covered dependents will continue to be eligible to receive healthcare retirement benefits. You will be required to contribute 25% of the premium cost, or the same dollar amount you were contributing for healthcare prior to your retirement, whichever is greater.

- If employed for more than five (5) years but less than ten (10) years as of September 1, 2003, and you become eligible for retirement, upon your retirement you and your covered dependents will continue to be eligible to receive healthcare retirement benefits. You will be required to contribute 25% of the premium cost for your individual coverage and 50% for your covered dependents, or the same dollar amount you were contributing for healthcare prior to your retirement, whichever is greater.

- If employed for less than five (5) years as of September 1, 2003, and you become eligible for retirement, upon your retirement you will be eligible to receive individual healthcare retirement benefits, but your covered dependents will not receive benefits at the University's expense. You will be required to contribute 25% of the premium cost, or the same dollar amount you were contributing for healthcare prior to your retirement, whichever is greater.

Administrators hired after September 1, 2003 are not eligible for postretirement healthcare benefits.

Administrators who have already retired are subject to the eligibility and contribution rules then in effect.

AAUP FACULTY EMPLOYEES

ACTIVE FACULTY

The provisions governing healthcare benefits for active faculty, including required contribution amounts, are set forth in Article 7, sections 7.1 – 7.6 and 7.9 (adjuncts) of the Collective Bargaining Agreement between Hofstra University and the Hofstra Chapter of the American Association of University Professors, expiring August 31, 2021.

RETIREE BENEFITS (Applicable to Faculty not yet retired)

The provisions governing healthcare benefits for certain AAUP faculty upon retirement, including required contribution amounts, are set forth in Article 7, sections 7.24 and 7.27 of the Collective Bargaining Agreement between Hofstra University and the Hofstra Chapter of the American Association of University Professors, expiring August 31, 2021.

AAUP faculty hired after September 1, 2006 are not eligible for healthcare coverage upon retirement.

LOCAL 153 EMPLOYEES

ACTIVE EMPLOYEES

The provisions governing healthcare benefits for active employees, including required contribution amounts, are set forth in Article XVI, sections 2, 3, 4, 6, 8 and 11 of the Collective Bargaining Agreement between Hofstra University and Office and Professional Employees International Union Local 153, AFL-CIO, expiring August 31, 2020.

RETIREE BENEFITS (Applicable to Employees not yet retired)

The provisions governing healthcare benefits for certain Local 153 employees upon retirement, including required contribution amounts, are set forth in Article XVII, section 7 of the Collective Bargaining Agreement between Hofstra University and Office and Professional Employees International Union Local 153, AFL-CIO, expiring August 31, 2020.

Employees hired after September 1, 2005 are not eligible for healthcare coverage upon retirement.

LOCAL 282 EMPLOYEES

ACTIVE EMPLOYEES

The provisions governing healthcare benefits for active employees, including required contribution amounts, are set forth in Article XXIII, Sections 2, 3, 4 and 5 of the Collective Bargaining Agreement between Hofstra University and Local 282, International Brotherhood of Teamsters, expiring July 31, 2018.

RETIREE BENEFITS (Applicable to Employees not yet retired)

The provisions governing healthcare benefits for certain Local 282 employees upon retirement, including required contribution amounts, are set forth in Article XXIII, section 7 of the Collective Bargaining Agreement between Hofstra University and Local 282, International Brotherhood of Teamsters, expiring July 31, 2018.

Employees hired after September 1, 2003 are not eligible for healthcare coverage upon retirement.

LOCAL 553 EMPLOYEES

ACTIVE EMPLOYEES

The provisions governing healthcare benefits for active employees, including required contribution amounts, are set forth in Section 4.2(a)(b)(c) and (d) of the Collective Bargaining Agreement between Hofstra University and Local 553, International Brotherhood of Teamsters, expiring November 14, 2018.

RETIREE BENEFITS (Applicable to Employees not yet retired)

The provisions governing healthcare benefits for certain Local 553 employees upon retirement, including required contribution amounts, are set forth in Section 4.2(e) of the Collective Bargaining Agreement between Hofstra University and Local 553, International Brotherhood of Teamsters, expiring November 14, 2018.

Employees hired after November 15, 2003 are not eligible for healthcare coverage upon retirement.

LOCAL 1102 EMPLOYEES

Healthcare benefits are provided to Local 1102 employees through the Local 1102 Health and Benefit Fund. The University makes contributions to the Fund in accordance with Article XXVIII of the Collective Bargaining Agreement, between Hofstra University and Local 1102 RWDSU UFCW, expiring July 31, 2019.

RETIRED EMPLOYEES

The eligibility rules for retired employees are those in effect at the time of retirement.

2017 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2017. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. The following is added to the Introduction section of your Benefit Booklet:

Your Employer has agreed to be subject to the terms and conditions of Empire's provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

B. The BlueCard and/or Inter-Plan Program provision language is hereby deleted and replaced with the following:

Inter-Plan Programs.

1. **Out-of-Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area We serve, (the "Empire Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

   When You receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

2. **BlueCard® Program.** Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

   When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:
   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to Us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. **Special Cases: Value-Based Programs.** BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments. Additional information is available upon request.

4. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

5. **Non-Participating Providers Outside Our Service Area.**

   a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Service Area by Non-Participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

   b. **Exceptions.** In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

6. **BlueCard Worldwide® Program.** If You plan to travel outside the United States, call Member Services to find out Your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with You.

   When You are traveling abroad and need medical care, You can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

   If You need inpatient hospital care, You or someone on Your behalf, should contact Us for preauthorization. Keep in mind, if You need emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

   How claims are paid with BlueCard Worldwide. In most cases, when You arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:
   - Doctors services;
   - Inpatient hospital care not arranged through BlueCard Worldwide; and
   - Outpatient services.

You will need to file a claim form for any payments made up front.

When You need BlueCard Worldwide claim forms, You can get international claim forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at *www.bluecardworldwide.com*.

You will find the address for mailing the claim on the form.

C. The Subrogation and Reimbursement provisions are hereby deleted and replaced with the following:

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

1. Subrogation

   The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

   The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

   You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

   In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

   The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

   To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

   The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

2. Reimbursement

   If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.

You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.

Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
You fail to cooperate.

In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

3. Your Duties

You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.

You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

You must not do anything to prejudice the Plan's rights.

You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

D. Provision language related to Special Enrollment Periods is hereby deleted and replaced with the following:

You, Your Spouse or Child, can also enroll for coverage within 60 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice within 60 days of the loss of coverage. The effective date of Your coverage will be the date indicated on the application.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice within 60 days of one of these events.. The effective date of Your coverage will be the date indicated on the application.

E. The following is added to the Exclusions and Limitations section of Your Benefit Booklet.

- **Conversion Therapy.** We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

2018 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2018. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. The BlueCard and/or Inter-Plan Program provision language is hereby deleted and replaced with the following:

Inter-Plan Programs

1. **Out-of-Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside of the geographic area We serve (the "Empire Local Network Area"), the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

   When You receive care outside of the Empire Local Network Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

2. **BlueCard® Program.** Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

   When You receive Covered Services outside the Empire Local Network Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:
   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to Us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

   Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. **Special Cases: Value-Based Programs.**

BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments.

4. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

5. **Non-Participating Providers Outside Our Local Network Area.**

   a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Local Network Area by non-participating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

   b. **Exceptions.** In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Local Network Area, or a special negotiated price to determine the amount We will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

6. **Blue Cross Blue Shield Global Core® Program.** If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United State may be different from services received in the United States. The plan only covers Emergency, including ambulance and Urgent Care outside of the United States. Remember to take an up to date health ID card with You.

   When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

   How claims are paid with BlueCard Worldwide. In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:
   - Doctors services;
   - Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
   - Outpatient services.

   You will need to file a claim form for any payments made up front.

   When You need Blue Cross Blue Shield Global Core claim forms, You can get international claim forms in the following ways:
   - Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or

- Online at *www.bcbsglobalcore.com*.

You will find the address for mailing the claim on the form.

B. The "Initial Decisions" section of the "Health Management" chapter of your benefit booklet is hereby deleted and replaced with the following:

1. Preauthorization Reviews.

a. Non-Urgent Preauthorization Reviews. If We have 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, in writing, within fifteen (15) calendar days of receipt of the request.

If We need additional information, We will request it within fifteen (15) calendar 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, in writing, within fifteen (15) calendar days of Our receipt of the additional 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 allowed to submit the additional information.

b. Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

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. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

c. Court Ordered Treatment. With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, 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 notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

2. Concurrent Reviews

4. Non-Urgent 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, in writing, within fifteen (15) calendar days of receipt of all necessary information.

If We need additional information, We will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

5. 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 (or Your designee) and Your Provider within 24 hours of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. 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. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

6. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

3. **Retrospective Reviews.** If We have 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.

4. **Retrospective Review of Preauthorized Services.** We 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.

C. The following provisions related to Claim Determinations are added to your benefit booklet:

1. **Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Booklet for information on how We coordinate benefit payments when You also have health coverage with another plan.

2. **Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all

necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at *www.empireblue.com*. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Booklet or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Booklet; on Your ID card or visiting Our website at *www.empireblue.com*.

3. **Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 18 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 18 months period, You must submit it as soon as reasonably possible.

4. **Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

5. **Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

   For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Booklet.

6. **Pre-Service Claim Determinations.**

   a. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 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.

   b. Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee), within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours of receipt of the request. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) within 48 hours of the earlier of Our receipt of the additional information or, if information was not received, at the end of the 48-hour period allowed to submit the information.

7. **Post-Service Claim Determinations.** A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or

the end of the 45 day period.

D. The definition of "Providers" is revised as follows:

- For behavioral healthcare purposes, "provider" includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic
يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bengali
আপনার আবদেন বা সুবধিার বষিয়ে এই বজ্ঞপ্তটিতিে গুরুত্বপূর্ণ তথ্য রয়ছে। গুরুত্বপূর্ণ তারখিগুলরি জন্য দখেুন। আপনার সুবধিাগুলি বজায় রাখার জন্য বা খরচ নয়িন্ত্রণ করার জন্য নর্দিষ্টি তারখিে আপনাকে কাজ করতে হতে পার। বনিামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধকিার আপনার আছ। সাহায্যরে জন্য আপনার আইডি কার্ডে থাকা সদস্য পরষিবো নম্বরে কল করুন। (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish
Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)

Tagalog
May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu
یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنےکے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہوسکتی ہے۔ آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Yiddish
דעם מעלדונג האט וויכטיגע אינפארמאציע וועגן אייער אפלעקאציע אדער קאווערידזש. קוקט פאר נויטיגע דאטעס אין דעם מעלדונג. איר וועט מעגליך דארפן נעמען אקציע קודם געווינסע דעדליינז צו האלטן אייערע געזונט קאווערידזש אדער העלפן מיט קאסט. איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. רופט די מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף(TTY/TDD:711).

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.