

Empire BlueCross BlueShield Medicare Related Program for The City of New York Group 157800

Health Plan

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CITY OF NEW YORK

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EMPIRE MEDICARE RELATED PROGRAM

General Information

The benefits and provisions explained in this booklet apply to retirees who are eligible, become insured and remain insured according to the provisions of the group contract. These benefits are not available if you are an active employee.

Your coverage is provided through your group and only you are covered by these benefits. If any of your dependents are not Medicare eligible, they may continue group coverage separately.

The benefits described below explain how your Empire Medicare Related hospital and medical coverage interacts with Medicare Part A hospital insurance and Medicare Part B medical insurance. In reading this section, keep in mind that Medicare provides two different kinds of coverage, as noted above. Medicare hospital insurance (Part A) helps you pay hospital bills. Medicare medical insurance (Part B) helps you pay doctors' bills and other services. But neither Part A nor Part B pays your bills in full. There are deductible and coinsurance amounts that you must pay. Your Empire Medicare Related hospital and medical benefits help to pay these amounts.

For example, if you're hospitalized because you need surgery:

- Medicare Part A combined with Empire Medicare Related *hospital benefits* provides coverage for room, board and general nursing care and other hospital costs
- Medicare Part B combined with Empire Medicare Related *medical benefits* helps you meet the cost of physicians' services and other services such as outpatient surgery.

The Medicare benefits described in this booklet are subject to any limitations established by the federal government and the benefits themselves can be changed by an Act of Congress. Empire BlueCross Blue Shield will not provide benefits for any service rejected by Medicare for a reason other than having used up all the available coverage. For example, if Medicare rejects a claim as unnecessary hospitalization, Empire Medicare Related benefits will not cover it, either.

How the Hospital (Part A) Program Works

Your hospital benefits pay for services provided by licensed hospitals when your physician orders hospitalization for the treatment of an illness or injury. The chart on page 3 outlines your hospital benefits.

A *hospital* is defined as an institution supervised by a staff of physicians providing both medical and surgical or obstetrical care and 24-hour nursing service by registered graduate nurses present and on duty.

Under your contract, none of the following are considered a hospital:

- skilled nursing facilities
- nursing or convalescent homes and institutions
- institutions primarily for rest; spas; sanitariums
- any institution (unless specially designated by Empire BlueCross BlueShield) primarily for treating drug addiction, alcoholism or mental disorders.

Medicare Part A does not provide benefits for services given outside the United States and its possessions. You may, however, receive benefits for the first 90 days of a single hospital confinement in a semi-private room outside the United States if:

- You receive necessary inpatient care in a non-governmental general hospital
- You are a U.S. resident and are eligible for Medicare Part A benefits
- You have not been outside the U.S. continuously for over 3 months
- The care is related to inpatient care received within 60 days before leaving the U.S., in which case you must have been outside the U.S. more than 15 consecutive days prior to the admission

You may also receive benefits for emergency care outside the United States. Please see the section, *Medically Necessary Emergency Care in a Foreign Country on page 6.*

How Much Is Covered?

In some cases, such as most semiprivate hospital care, the combination of Medicare and your Empire Medicare Related hospital benefits will cover the full amount. But in other cases, you may only be eligible to receive benefits for a portion of your expenses. And some expenses don't qualify for any benefits.

Medicare provides benefits after a deductible and coinsurance for the first 90 days in the hospital. Your Empire Medicare Related hospital coverage

- covers the Medicare deductible and the coinsurance for the first 90 days and
- covers an additional 275 days (from the 91st to the 365th day) in the hospital after you use your Medicare lifetime reserve days
- covers the coinsurance in conjunction with your Medicare 60-day lifetime reserve days.

Benefit Period

Medicare Part A coverage for necessary hospitalization is available for each benefit period, beginning when you enter a hospital. Successive stays in one or more hospitals or skilled nursing facilities count as one benefit period unless 60 days or more elapse between the discharge date and the next admission. If 60 days have elapsed since the last discharge, the new hospital stay starts a new benefit period.

Additional Empire BlueCross BlueShield Hospital Days

If during a Benefit Period you have used all your Medicare hospital days, including your Medicare lifetime reserve days, then we will pay for additional days of inpatient hospital care in the same Benefit Period. We will only pay for such additional days if, in our sole judgement, it is medically necessary for you to be hospitalized. We will not pay for more than three hundred and sixty-five (365) of such additional days during your lifetime. Our payment for each such additional day of inpatient care will be limited to (1) the kind of expenses which would have been paid under Medicare, (2) only when you are hospitalized in a short term acute care general hospital which qualifies under Medicare, and (3) only when Medicare would have made payment if you had not used all your Medicare days.

Covered Hospital Services

Benefits Provided Under Medicare Part A and Empire Medicare Related Hospital Coverage (Based on Semiprivate Accommodations)

COVERED SERVICES	MEDICARE PART A	EMPIRE MEDICARE RELATED HOSPITAL
<i>In the United States</i>		
1st-60th day	Covered except for deductible	Covers deductible
61st-90 th day	Covered except for coinsurance amount per day of 1/4 of deductible amount	Covers coinsurance
Beyond 90th day	No coverage except for lifetime reserve days	No coverage unless lifetime reserve days are used
60-day lifetime reserve	Covered except for coinsurance amount per day of 1/2 of deductible amount	Covers coinsurance
Beyond 90th day when 60-day lifetime reserve is exhausted	No coverage	Covers total of 365 days in full per lifetime, except psychiatric confinement in psychiatric hospitals
Skilled Nursing Facility	Covered for 100 days in skilled nursing facility except for the copayment amount from the 21 st through 100 th day	Pays the copayment amount from the 21 st through 100 th day

Blood Deductible Under Medicare

We will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Part A or Part B of Medicare each year, unless the blood is replaced in accordance with federal regulations.

How The Medical (Part B) Program Works

Your Empire Medicare Related medical coverage provides benefits in addition to those you receive under Medicare Part B. Medical benefits cover services provided by individual practitioners and hospital charges for outpatient emergency care or surgery. Practitioners include any of the following:

- licensed physicians
- osteopaths
- physical therapists
- psychologists

We will pay the coinsurance amount of the Medicare allowed charge, if any, regardless of hospital confinement. If your bill is higher than the allowed charge, neither Medicare nor we will pay the difference nor will we pay anything if Medicare pays you one hundred (100) percent of its allowed charge.

Covered Medical Services

Medical Coverage Provided Under Medicare Part B and Empire Medicare Related Medical Coverage

COVERED SERVICES	MEDICARE PART B	EMPIRE MEDICARE RELATED MEDICAL
<p><i>Inside the U.S.</i></p> <p>In or out of the hospital and outpatient hospital treatment such as:</p> <ul style="list-style-type: none"> ◆ Physician's services ◆ Inpatient and outpatient: <ul style="list-style-type: none"> ⇒ medical services ⇒ surgical services ⇒ supplies ⇒ physical and speech therapy ⇒ x-rays ⇒ durable medical equipment ⇒ bone mass measurement ⇒ colorectal cancer screening ⇒ diabetes glucose monitors, test strips, lancets and self-management training ⇒ mammogram screening ⇒ prostate cancer screening 	<p>Pays 80% of Medicare allowed charges AFTER Medicare Part B individual deductible</p>	<p>Pays 20% of Medicare allowed charges AND reimburses the Medicare Part B deductible</p>
<p><i>Outside the U.S.</i></p>	<p>Not covered</p>	<p>Pays 80% of allowed charges for same services covered in the U.S.</p>

Medically Necessary Emergency Care In A Foreign Country

Your coverage pays benefits, as described below, for emergency hospital, physician, and medical care in a foreign country which would be covered under Medicare if you had received the care within the United States.

Emergency care means care needed immediately because of an injury or an illness of sudden and unexpected onset. In each calendar year, we will pay eighty percent (80%) of the billed charges for expenses for necessary emergency care, subject to a fifty thousand dollar (\$50,000) lifetime maximum.

The emergency care must begin during the first sixty (60) consecutive days of each trip outside the United States. Payment will not be made for any emergency care you receive in a foreign country which is covered by Medicare, except that we will pay the regular deductible and/or coinsurance as previously described in this booklet.

Private Duty Nursing

If your physician authorizes private duty nursing, your Empire Medicare Related Program will pay 80% of approved charges after the first 72 hours after you have met the \$100 deductible.

Optional Prescription Drug Benefits

If you elected the optional prescription drug rider, benefits are as follows:

For Retail Pharmacy:

- \$0 deductible
- \$0 copay for select generics
- \$10 co-payment for 30 day supply of generic drugs
- \$25 co-payment for 30 day supply of brand-name drugs
- \$50 co-payment for 30 day supply of non-formulary drugs
- 25% co-insurance for non specialty & specialty injectables, specialty drugs (generic & brand)
Specialty limited to a 30 day supply

For Mail Order Pharmacy Only:

- \$0 deductible
- \$0 co-payment for select generics
- \$20 co-payment for 90 days supply of generic drugs
- \$50 co-payment for 90 days supply of brand-name drugs
- \$100 co-payment for 90 days supply of non-formulary drugs
- 25% co-insurance for non specialty & specialty injectables, specialty drugs (generic & brand)
Specialty limited to a 30 day supply

Your payment responsibility changes once you reach your initial coverage limit of \$2,700. Coverage gap member pays 50% (retail & mail)

After your yearly out-of pocket costs reach \$4,350, you pay the following:

- \$2.40 co-payment for generic drugs or 5% whichever is greater (including brand drugs treated as generic) and \$6.00 co-payment or 5% whichever is greater for all other drugs.*

Lesser than logic applied-if cost of script is less than co-payment, member pays cost of script

* Subject to CMS changes for 2009

EXCLUSIONS AND LIMITATIONS

Some of the following exclusions apply to both your Empire Medicare Related hospital and medical coverages; others apply to hospital or medical only. It's a good idea to check this section before you file for benefits. It could save you the time and trouble of submitting a claim for a service that isn't covered. When the limitations and exclusions apply to a hospital stay, no benefits will be available for any part of the hospital charges for the day or days to which they are applied.

The following are not covered by either *hospital or medical* benefits:

- benefits available for services that Medicare has made payment for unless Medicare rejected the claims or refuses to make payment because Medicare benefits have been exhausted.
- benefits available to you under Medicare which you did not receive only because you failed to enroll or file for those benefits. However, your failure to use all or part of your 60 day lifetime reserve for inpatient care will not be considered a failure to enroll for Medicare benefits.
- services that are not needed for your proper medical care or treatment of an illness or injury;
- care in United States government hospitals or under federal, state, county, municipal or foreign government programs (except Medicaid);
- services for which Workers' Compensation benefits or mandatory automobile under no-fault automobile insurance is available;
- services usually provided without charge or for which a claim is not filed;
- elective cosmetic surgery, except for reconstructive surgery which is part of an operation to treat an infection, injury or a disease, or which follows such an operation or to treat a functional defect resulting from congenital disease;
- routine physical checkups.

Additionally, in no event will the total of the Medicare payment plus the payment under your Empire Medicare Related contract be more than the Medicare allowed charge for the services received.

The following expenses are not covered by *hospital* benefits:

- non-acute hospital care such as that portion of a hospital stay which is primarily custodial or for a rest cure or for convalescent or sanitarium-type care. However, when payment for such care is approved by Medicare, this exclusion will not apply;
- non-institutional services by practitioners;
- hospital care for mental or nervous conditions other than those which can reasonably be expected to improve with treatment

- ambulance or ambulette service.

The following expenses are not covered by *medical* benefits:

- services by practitioners beyond the scope of their licenses or of hospital employees unless specified under your Medicare Part A coverage;
- eyeglasses, contact lenses (except when medically necessary following cataract surgery) or hearing aids including fitting or examination for them.
- routine care of the feet including corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet
- services provided outside a hospital except for surgical services and dialysis
- all prescription drugs and insulin (unless covered under the optional prescription rider)

HOW TO CLAIM BENEFITS

Empire Medicare Related Hospital Claims

Inpatient Services

At the time of admission to a hospital in the United States, show both your Medicare and your Empire BlueCross BlueShield identification cards. Both Medicare and Empire BlueCross BlueShield will pay the hospital directly for covered hospital services. If you receive care outside the United States, pay the bill and get a receipted itemized statement which shows your name, home address, identification number and diagnosis. Mail the statement to:

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

Outpatient Services

Show both your Medicare and Empire BlueCross BlueShield identification cards at the hospital. Some hospitals outside the plan area may require you to pay the amount not covered by Medicare. If so, get an itemized receipted bill from the hospital showing your payment and send this to Empire BlueCross BlueShield at the above address, together with your statement of Medicare benefits used.

Empire Medicare Related Medical Claims

Obtain a Medicare Request for Payment form from your doctor or Social Security office. Complete and sign your part of the form. The doctor will complete his or her part, or instead, you may attach the doctor's bill showing the diagnosis.

If your doctor's office is anywhere in the southern 17 counties of New York State, except Queens, mail the Medicare form to:

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

After we process your Medicare payment, we will automatically send you any payment due under your Empire Medicare Related coverage.

COORDINATION OF BENEFITS

Occasionally, individuals have health care coverage under two programs. This commonly happens when a husband and wife both have employee health coverage that includes family members. When this occurs, the two programs coordinate benefit payments so that total payments do not exceed the actual expenses incurred by the insured.

The Coordination of Benefits provision of your contract establishes which health coverage program has primary responsibility and which has secondary responsibility when an individual is covered by more than one group plan. The primary health program must reimburse you first. If Empire is the secondary program, we will reimburse you for the remaining expenses (up to the Allowed Amount) for the covered services.

How Empire Determines Primary Coverage

To determine primary coverage, we use the following criteria; and in the following order:

- If the other health coverage program does not have a coordination of benefits provision similar to this one, that plan will have primary responsibility.
- If the covered person receiving benefits is the member of the Group covered by the contract, and is only a dependent under the other plan, this contract will be primary.
- A dependent child covered under both parents' health coverage programs will receive coverage as follows:
 - ⇒ the program of the parent whose birthday comes earlier in the calendar year (i.e., month and day) will have primary responsibility
 - ⇒ the health coverage program covering the parent longer will be primary, if the parents have the same birthday
 - ⇒ the father's health coverage program will have primary responsibility if the other health coverage program both does not have a "birthday" provision and uses gender to determine primary responsibility.

A dependent child covered by divorced or separated parents who have no court decree establishing 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 has remarried, and the child is also covered by the step-parent's program we use the following order to determine primary responsibility:

- ⇒ the custodial parent's plan pays first
- ⇒ the step-parent's program pays second and the non-custodial parent's plan pays third.

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 plan once that plan has actual knowledge of that decree.

- Coverage of active employees and their dependents are primary to coverage for laid-off employees, retired employees, or their dependents. This rule applies only where both programs in question have this rule, and the two insurance carriers agree which coverage is primary.
- If none of the previous rules apply, the health program that has covered the patient the longest will have primary responsibility.

Effects of Coordination

When the Empire MedicareRelated contract is secondary to another insurance carrier, the benefits of this plan will be reduced so that the total benefits paid or provided by the Primary Plan(s) and this Plan during a claim determination period will not exceed the total allowable expenses. Also, the amount we pay or provide will not be more than the amount we would pay or provide if we were primary.

ENDING AND CONTINUING COVERAGE

WHEN COVERAGE ENDS

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

- Your group terminates the contract
- Your employer no longer meets our underwriting standards
- Your employer fails to pay premiums
- You fail to pay premiums (if required)
- The covered employee dies
- You or your covered dependents no longer meet your employer's or the contract's eligibility requirements
- You or your covered dependents have made a false statement on an application for coverage or on a health insurance claim form, or you or your group have otherwise engaged in fraud
- Empire discontinues this class of coverage

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.

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 you elect continuation coverage, 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 the Group Benefits Administrator 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 coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. 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. 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, in the case of an 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 the NYC Health Benefits Program, 40 Rector Street 3rd Floor, New York, NY 10006, 212-306-7753.

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.

CONTINUING COVERAGE UNDER NEW YORK STATE LAW

If you are not entitled to continuation of coverage under COBRA (for example, your employer has fewer than 20 employees), you may be entitled to continue coverage under New York State Law. These laws vary from those under COBRA, but generally also require continued coverage for up to 18, 29 or 36 months.

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

THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004

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

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

RESERVISTS SUPPLEMENTARY CONTINUATION AND CONVERSION

If the group's plan qualifies as an employer group health plan subject to federal continuation of coverage provision of COBRA, previously described, the supplementary continuation and conversion right described in this section does not apply.

- If a covered member who is a member of a reserve component of the armed forces of the United States, including the National Guard, enters upon active duty and the group does not voluntarily maintain coverage for such member, coverage will be suspended unless the member elects in writing, within 60 days of being ordered to active duty, to continue coverage under this program for the covered member and their eligible covered dependents. Such continued coverage shall not be subject to evidence of insurability. The member must pay the group the required group rate premium in advance, but more frequently than once a month.
- Reservists' supplementary continuation will not be available to any person who is, could be, covered by Medicare or any other group coverage. Coverage available to active duty members of the armed forces will not be considered group coverage for the above purposes.
- In the event that the Member is re-employed or restored to participation in the Group upon return to civilian status after the period of continuation of coverage or suspension, the member will be entitled to resume coverage under program for the member and eligible dependents. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty. No exclusion or waiting period will be imposed in connection with resumed coverage except regarding:
 - a condition that arose during the period of active duty and that has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or
 - a waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that the covered member is not re-employed or restored to participation in the group upon return to civilian status, the member shall have the right within 31 days of the termination of active duty, or discharge from hospitalization, incident to active duty which continues for a period of not more than one (1) year, to submit a written request for continuation to the group, or a request for conversion directly to Empire, as described in this booklet. Such individual conversion policy will be

effective on the day after the end of the period of supplementary continuation. If the member elects supplementary continuation or if coverage is suspended, the supplementary conversion right will be available to the member's spouse if divorce or annulment of the marriage occurs during the period of active duty, and, in the event the member dies while on active duty, to the member's spouse and children, and to each individually upon attaining the limiting age of coverage under this program, but not the child's dependents.

BENEFITS AFTER TERMINATION

If we determine you are totally disabled on the date your coverage under this Plan terminates, we will pay for your care in a hospital as described in Section Three and for surgery if all of the following conditions are met:

- A.** The hospital confinement begins, and the surgery takes place, during the first 31 days after your coverage under this Plan terminates.
- B.** You remain totally disabled during the entire hospital confinement.
- C.** The hospital confinement is primarily for care of the condition which caused you to be totally disabled.

If coverage under this Plan terminates under paragraph 3 above because the employee whose name appears on the identification card is no longer an active employee of the group contract holder, then we will also pay for the benefits described in the Extended Medical Section of this Plan for such employee or any member of the employee's family covered under this Plan who meets the following conditions:

The person is totally disabled on the date coverage under this Plan terminates and continues to be totally disabled. We will no longer make payments for Extended Medical benefits once the person is no longer totally disabled; and

The person is not covered under another group health benefits program, whether it is insured, self-insured or self-funded. We will no longer make payments for Extended Medical benefits once the person becomes covered under another health benefits program, and

The care is not more than the person would have been entitled to receive if the person's coverage under this Plan had not terminated; and

- A.** The care is not provided more than twelve months after coverage under this Plan terminates.

ENDING AND CONTINUING COVERAGE

Your employer reserves the right to amend or terminate its group health plan coverage provided to you at any time without prior notice or approval. The decision to end or amend the health plan coverage may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason.

Any amendment or termination may apply to all or any portion of the group health plan coverage and to all or to only a portion of the participants and beneficiaries.

PORTABILITY OF COVERAGE

Your contract may require an 11-month waiting period before paying benefits for pre-existing conditions. At the same time you may be eligible for credit toward the satisfaction of this waiting period. If you had similar coverage (hospital, medical or major medical) from another insurance carrier before the effective date of your Empire coverage, you will receive credit for whatever waiting period you met under the prior contract (Creditable Coverage). The pre-existing condition provision in your Empire contract provides that credit towards the pre-existing condition waiting period will be given for the time you were

previously covered under Creditable Coverage of a prior plan, if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the enrollment date under your Empire plan. Please note that you have a right to request a certificate of Creditable of Coverage from a prior plan or issuer, free of charge, and that Empire will assist you in obtaining a certificate from any prior plan or issuer, if necessary.

To determine whether you are eligible for portability of coverage, you must provide Empire with the certificate of Creditable of Coverage or a letter of proof from the prior carrier or group that contains the covered person's name, contract type, start and end dates of coverage, and names of covered dependents. The evidence of prior coverage should be submitted immediately to avoid possible claim rejections.

COMPLAINTS, APPEALS AND GRIEVANCES

Complaints

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. If you have a complaint about any of the healthcare services your plan offers, plan procedures or our customer service call Member Services. Member Services may ask you to put your complaint in writing if it is too complex to handle over the telephone.

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

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

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

Provider Quality Assurance

Because your healthcare is so important, Empire has a Quality Assurance Program designed to ensure that our network providers meet our high standards for care. Through this program, we continually evaluate our network providers.

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns directly with your provider. If you are still not satisfied, you can submit a complaint at the above address. Empire will refer complaints about the clinical quality of the care you receive to the appropriate clinical staff member to investigate.

We also encourage you to send suggestions to Member Services for improving our policy and procedures. If you have any recommendations on improving our policies and procedures, please send them to the above address.

Your Right to Appoint a Representative

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

Standard Internal Appeals

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

Level 1 Appeals

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

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

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

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

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

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

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

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

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

Expedited Level 1 Appeals

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

- You want to continue healthcare services, procedures or treatments that have already started
- You need additional care during an ongoing course of treatment

- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

You or your provider will have reasonable access to our clinical reviewer within one business day of Empire's receipt of the request.

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

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

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

Level 2 Appeals and Timeframes

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

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

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

External Appeals

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

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

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

To Obtain An External Appeal

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

The New York State Department of Insurance at 1-800-400-8882 or *www.ins.state.ny.us*
Empire Member Services at 1-800-342-9816.

Resolving an External Appeal

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

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

Submit your appeal within 45 calendar days.

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

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

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

Standard External Review Process

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

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

Expedited External Appeals

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

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

Level 1 Grievances

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

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

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

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

We will make a decision within the following time frames for 1st Level Grievances:

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

Level 2 Grievances

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

We will make a decision within the following time frames for 2nd Level Grievance:

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

Expedited Grievances

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

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

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

Decision on Grievances

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

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

How to File an Appeal or Grievance

To submit an appeal or grievance, call Member Services at 1-800-342-9816, or write to the following address with the reason why you believe the administrative decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

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

THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Empire feels it is important for every member to know his/her rights, so please review the following information.

If your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections under ERISA. Under ERISA you are entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor or Internal Revenue Service.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each covered member with a copy of this summary annual report.

Duties of the Plan Fiduciaries

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

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a covered member of the plan.

- Under ERISA, you have the right to have your Plan Administrator review and reconsider your claim. If we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal our decision. You, or your authorized representative, may submit a written request for review. You have the right to obtain copies of documents relating to the decision without charge. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a state or federal court. A lawsuit for benefits denied under this coverage can be filed no earlier than 60 days after the claim was filed, and no later than two years from the date that the services were received. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a 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**

Access to Information

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 copy of Empire's Drug Formulary indicating included and/or excluded drugs.
- 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.

CONFIDENTIALITY POLICY

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

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

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

AMENDMENT TO MEMBER'S EVIDENCE OF COVERAGE

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

You are hereby notified that pursuant to Empire HealthChoice Inc.'s conversion to a for-profit health insurer and corporate merger with Empire HealthChoice Assurance, Inc., all references in your certificate of coverage and/or benefit booklet ("evidence of coverage") to "Empire HealthChoice, Inc." are hereby changed to "Empire HealthChoice Assurance, Inc."

Any claim or any right against Empire HealthChoice, Inc. you may have had under your group's contract as of the date of the conversion and merger (including, but not limited to, a right to receive payments for services incurred prior to the date of the conversion and merger) will, as a result of the conversion and merger, be against Empire HealthChoice Assurance, Inc. instead. All benefits for services received on or after the date of the conversion and merger shall be the responsibility of Empire HealthChoice Assurance, Inc.

All correspondence and inquiries concerning your coverage, including premium payments, contract changes, and notices of claims, should be submitted to:

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

Except as set forth in this Amendment, your rights as a group member will not be affected and the terms and conditions of your coverage will not be changed by reason of the conversion and merger. This Amendment forms a part of and should be attached to your evidence of coverage issued to you by Empire HealthChoice, Inc.

This Amendment hereby amends your evidence of coverage by adding the following provisions:

1. The group contract is between your group and Empire HealthChoice Assurance, Inc.
2. No statement you make will avoid the insurance provided by the contract or evidence of coverage, or reduce its benefits, unless it is contained in a written document you have signed. All statements contained in such a document will be deemed representations, not warranties.
3. No agent has authority to change the contract or evidence of coverage or waive any of its provisions. No change in the contract or evidence of coverage shall be valid unless approved by an officer of Empire HealthChoice Assurance, Inc. and evidenced by endorsement on the contract. A change may also be valid when it is in the form of an amendment to the contract signed by the group and Empire HealthChoice Assurance, Inc.

4. All new employees or new members in the classes eligible for insurance must be added to the class for which they are eligible.
5. **CONVERSION.** The provisions of the group contract and your evidence of coverage that describe the conversion privilege upon termination of coverage are hereby amended to delete references to “direct payment contract” and replace such references with “individual Medicare Supplement contract”. In addition to your right to purchase the individual Medicare Supplement contract that has the same benefits as your contract, you may purchase any other individual Medicare Supplement contract offered by Empire HealthChoice Assurance, Inc.
6. The provisions of the group contract and your evidence of coverage that describe claim submission requirements are deleted and replaced with the following:

Written proof of claim for benefits covered under the contract must be furnished to Empire within ninety days after the date services were rendered. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

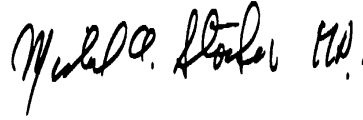
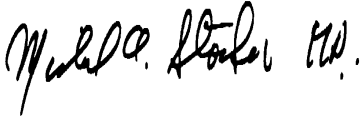
Empire will furnish to the person making claim or to the group for delivery to such person, upon request, such forms as are usually furnished by it for filing proof of claim. If such forms are not furnished in response to such request, the person making such claim shall be deemed to have complied with the requirements of the contract as to proof of claim upon submitting within the time fixed in the contract for filing proof of claim, written proof covering the occurrence, character and extent of the services for which claim was made.

7. Benefits payable under the group contract and your evidence of coverage will be payable not more than 45 days after receipt of a claim, except in a case where our obligation to pay a claim submitted is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the Insurance Department that such claim was submitted fraudulently.
8. The provisions of the group contract and your evidence of coverage that describe who will receive payment under the contract are deleted and replaced with the following:

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

9. All terms, conditions, limitations, and exclusions of the group contract and evidence of coverage apply to this Amendment except where specifically changed herein. If there are any inconsistencies between this Amendment and the group contract and evidence of coverage, the provisions of this Amendment shall control.

IN WITNESS WHEREOF, Empire HealthChoice, Inc. and Empire HealthChoice Assurance, Inc. have caused this Amendment to Member's Evidence of Coverage to be duly signed and issued.



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

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