Empire Dental Preferred℠
Research Foundation of CUNY
Group 174426 H, P, FE, FR, GP, GS

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.
Blue Cross, Blue Shield, the Cross and Shield symbols and BlueCard are registered marks of the Blue Cross and Blue Shield Association.
The Butterfly is a service mark of Empire HealthChoice Assurance, Inc.
5/2011

Research Foundation of CUNY

GROUP NUMBER: 174426-H, P, FE, FR, GP, GS

TABLE OF CONTENTS

DENTAL PPO BENEFITS SUMMARY 1
IMPORTANT TELEPHONE NUMBERS 2
INTRODUCTION 3
What is a Dental PPO? 3
How Dental PPO Works 3
Deductible 4
Annual Benefit Maximum 4
Eligibility 4
Dependent Children 4
Effective Date of Coverage 9
Our Role in Notifying You 9
NETWORK BENEFITS 9
IN-NETWORK BENEFITS 10
In-Network Reimbursement 10
How To Choose A Dentist 10
Benefit Percentage 11
OUT-OF-NETWORK BENEFITS 12
Benefit Percentage 12
Deductible 12
COVERED DENTAL SERVICES 13
In-Network Benefit Percentage 100% 13
LIMITATIONS AND EXCLUSIONS 22
COORDINATION OF BENEFITS 25
How Empire Determines Primary Coverage 25
CLAIMING BENEFITS 27
Benefits Precertification 27
Claiming Benefits 28
Claim Review 28
TERMINATION AND CONTINUATION OF COVERAGE 30
Termination of Coverage 30
Under State Law 35
Ending and Continuing Coverage 35
COMPLAINTS, APPEALS AND GRIEVANCES 36
To Obtain An External Appeal 38
STATEMENT OF ERISA RIGHTS 42
YOUR RIGHTS AND RESPONSIBILITIES 45
HIPAA NOTICE OF PRIVACY PRACTICES 46
AMENDMENT TO MEMBER'S EVIDENCE OF COVERAGE 50

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 there is a difference between the information in this booklet and the actual contract, the contract always governs. Please consult your group's contract for additional information.

DENTAL PPO BENEFITS SUMMARY

This summary of your Dental PPO program is not a full contractual description of your benefits. Please see your group's contract for more information about covered services, limitations and exclusions.

PROGRAM BENEFITS	IN-NETWORK DENTIST (1)	OUT-OF-NETWORK (2)
ANNUAL DEDUCTIBLE	$0	$50 Individual, $100 Family Maximum
ANNUAL MAXIMUM	$2,500	
EMPIRE ALLOWED AMOUNT	**IN-NETWORK FEE SCHEDULE** (3)	**OUT-OF-NETWORK FEE SCHEDULE** (3)
DIAGNOSTIC & PREVENTIVE SERVICES	100%	80%
BASIC SERVICES	100%	80%
MAJOR SERVICES	60%	50%
(IF RIDER)ORTHODONTIC SERVICES** active treatment, including diagnosis, models, photographs, necessary appliances and all adjustments. ***Available only to children up to age 19***.	50% up to a lifetime maximum of $1,750	
DEPENDENT CHILDREN	Dependents to 26	

(1) When services are performed by a PPO Network provider.
(2) When services are provided by an Out-of-Network provider.
(3) There may be Fee Schedules for different geographic areas.

IMPORTANT TELEPHONE NUMBERS

Do you have a question about your benefits? We're here to help you. Call this toll-free number for quick, courteous answers to your questions.

Dental PPO Member Services 1-800-722-8879
For questions about your benefits, claims, or membership.

STOP FRAUD

Empire BlueCross BlueShield welcomes your help
in preventing dental 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).

INTRODUCTION

Your Dental plan, is a group plan available to you through an insurance policy issued and underwritten by Empire BlueCross BlueShield. With Empire Dental Preferred, you have a dental insurance program designed to help you get dental benefits at the lowest possible cost, and dedicated to helping you maintain good oral health.

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.

This benefit booklet is a guide to your Empire Dental Preferred coverage. It tells you how to get quality dental care from the dentist *you* choose, control your out-of-pocket expenses, and avoid filing claims. Please read this material and call Empire if you have any questions. Please be aware that this booklet is a summary of your employer's legal contract which controls any disputes. If you would like to consult your contract, please contact your group benefits administrator.

What is a Dental PPO?

Your PPO program is a dental plan built around the Empire Dental Preferred network of dentists. You may receive care from any licensed dentist. Empire Dental Preferred dentists have signed agreements with Empire to provide services, limit their fees according to the Empire Dental Preferred allowed amount and submit claims for covered services directly to Empire. As you can see in your **BENEFITS SUMMARY**, most services have two levels of payment, depending on whether the care was delivered In-Network or Out-of-Network. You may receive care from any licensed dentist, but when you use In-Network providers your out-of-pocket expenses for your dental care services will be lower, and you will virtually never have to submit a claim and wait for payment.

How Dental PPO Works

Each time you need dental care services, Empire Dental Preferred allows you to choose whether to receive your care In-Network or Out-of-Network. You may decide to receive In-Network benefits for some services and Out-of-Network benefits for others. The reimbursement level changes, depending on whether services are In-Network or Out-of-Network. When you choose Out-of-Network benefits, you will have generally more out-of-pocket costs.

**REMEMBER
YOU'LL HAVE LOWER OUT-OF-POCKET COSTS
WHEN YOU GO TO IN-NETWORK PROVIDERS
FOR YOUR DENTAL CARE.**

Deductible

A deductible is the payable amount of covered expenses that you must pay out of your own pocket before services are covered. Each calendar year, you must pay a $ 50 individual and $100 family deductible before Dental PPO provides benefits for *Out-of-Network services.*

Annual Benefit Maximum

This program's *annual* maximum is $2,500 per member. For orthodontics, there is a separate lifetime maximum of $1,750.

The annual maximum includes all reimbursement paid by Empire for In-Network and Out-of-Network claims combined.

Eligibility

You are eligible for individual, husband and wife, parent-child/children or family coverage

- **Individual** covers only you

- **Husband and Wife Covers**
- You and your spouse or your domestic partner

- **Parent-Child/Children Covers:**
- You and your eligible child/children

- **Family** covers you, plus one or more of the following:
  - ⇒ Your spouse or domestic partner
  - ⇒ Each unmarried dependent child (natural or adopted).

If a member marries and transfers to husband or family coverage within 60 days of the marriage date, Empire provides continuous coverage from previous coverage as of the marriage date. The employer, however, must notify Empire in writing requesting a status change.

Dependent Children

Empire covers dependent children under the following circumstances:

- end of the calendar month following the calendar month in which the dependent reaches age 26.

This policy also covers:

- Unmarried incapacitated children who are unable to support themselves because of physical handicap, mental illness, developmental disability, or mental retardation as defined by New York State Law, provided the incapacitating condition started before the age at which coverage for unmarried dependent children would have otherwise terminate, December 31 of the year in which the child becomes the age listed above. Empire may require that a physician certify the child's condition.
- **Adopted *newborns*** are covered from the moment of birth if the adoptive parent takes custody of the infant as soon as the infant is released from the hospital after birth, the newborn is dependent upon the adoptive parent pending finalization of the adoption, **and** the parent files an adoption petition with New York State within 30 days of the infant's birth.

  However, adopted newborns will **not** be covered from the moment of birth if (1) one of the child's natural parents has coverage for the newborn's initial hospital stay; (2) a notice revoking the adoption has been filed; or (3) one of the natural parents revokes their consent to the adoption.

The Dental PPO does **not** cover foster children.

Adding or Removing a Dependent

If you need to change coverage categories or add 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 add or remove a dependent are:

- Having a baby
- Getting married
- 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.

If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the group's open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage within 30 days after the qualifying event.

Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through your employer.

If you or your eligible dependents rejects initial enrollment, you and your eligible dependents can become covered for this program as follows:

- You or your eligible dependent was covered under another plan at the time coverage was initially offered, or
- Coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
- Coverage under the other plan was subsequently terminated as a result of loss of eligibility for one of the following:

- ♦ Termination of employment
  - ⇒ Termination of the other plan
  - ⇒ Death of the spouse
  - ⇒ Legal separation, divorce or annulment
  - ⇒ Reduction in the number of hours of employment, or
- ♦ Contract holder contributions toward the premium payments for the other plan were terminated

MEDICAID AND CHIP SPECIAL ENROLLMENT/SPECIAL ENROLLEES

Eligible Employees and Dependents may also enroll under two additional circumstances:

- ➢ the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- ➢ the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

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. If your children are eligible for employer-sponsored coverage on their own, then they are not eligible for dependent coverage to age 26. Coverage for these children ceases on the date otherwise specified under Your Plan.

   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 month in which] the child turns 26 years of age.

C. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self- sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

D. The provisions of any Rider to Your Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph [7] that apply to children under the age of 26.

EMPIRE HEALTHCHOICE ASSURANCE, INC.
RIDER TO YOUR CERTIFICATE OR CONTRACT

EXTENSION OF COVERAGE
FOR ELIGIBLE DEPENDENTS THROUGH AGE 29

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice Assurance, Inc. to which it is attached as described below.

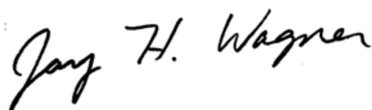
This Rider increases the maximum coverage age through age 29 for young adult dependents who meet the eligibility requirements listed below.

To be eligible the dependent must be:
1. a child of a covered member;
2. unmarried;
3. under age 30; [and]
4. not insured by or eligible for coverage through the dependent's own employer-sponsored group policy, whether insured or self-insured[; and]
5. [live, work or reside in New York State].

The dependent must also meet the eligibility requirements set forth in the Contract, Certificate or Group Plan.

The extended dependent coverage provided by this Rider will terminate on the date the parent of the covered dependent ceases to be eligible for coverage. Coverage will also terminate if the dependent fails to meet any of the eligibility requirements listed above. In addition, the basis for termination contained in the Contract, Certificate or Group Plan to which this Rider is attached, also apply.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached, including any applicable pre-existing condition limitations, also apply to this Rider, except where specifically changed by this Rider.



[Jay H. Wagner
Corporate Secretary]

[Mark Wagar
President]

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 an employee.

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.

Effective Date of Coverage

Your Dental PPO benefits begin either on the effective date of your group's coverage if you are a member of the group on that date or when Empire accepts your complete enrollment information. For a family membership, coverage for your spouse and dependents becomes effective only after you send Empire a completed Notice of Election and Enrollment Form.

If you marry and notify Empire within 60 days of the marriage, family coverage will begin on the marriage date. Otherwise, family coverage begins on the date when we accept complete enrollment information.

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.

IN-NETWORK BENEFITS

In order to receive In-Network benefits, you must receive treatment from a dentist participating in the Empire Dental Preferred Network.

When an In-Network dentist provides your care, Empire usually covers the services in full, except for any applicable coinsurance. Empire pays network dentists directly, so you won't need to send claim forms and wait for payment.

In-Network Reimbursement

For all covered dental services, Empire will make payment directly to the participating Empire Dental Preferred dentist based on Empire's Allowed Amount for In-Network services, less any coinsurance. The participating dentist will only bill the member the difference between the amount paid by Empire and the allowed amount. This includes amounts over the annual maximum and non-covered amounts.

For services not covered under the Dental coverage, the participating dentist may **not** charge more than Empire's Allowed Amount for that covered service. If the service has no Allowed Amount, the dentist may **not** charge more than 80% of his usual fee for that service.

How To Choose A Dentist

If you have family coverage each family member may use a different dentist. You may change Empire Dental Preferred dentists at any time simply by making an appointment with the new participating dentist of your choice. Empire does not require any notification when you make a change.

To choose a dentist, first decide whether you prefer a dentist close to your home or near your workplace. Then turn to the listing in your Empire Dental Preferred Directory for that county. Dentists are listed in the directory alphabetically by county and type of practice. Select your dentist and call the office directly to schedule your first appointment.

When you make your first appointment for routine treatment or specialty care, inform the dentist that you are a member of the Empire Dental Preferred Program. Have your ID card available to answer questions about your dental coverage.

Benefit Percentage

This program pays a percentage of the cost for covered dental services based on Empire's Allowed Amount for the geographic area. You must pay any deductible and any balance of these costs.

Covered dental services will be paid as follows:

- 100% for Diagnostic and Preventive services
- 100% for Basic services
- 60% for Major Services
- 50% for Orthodontics.

OUT-OF-NETWORK BENEFITS

If you receive dental services from a non-participating dentist, benefits will be paid based on Empire's Schedule of Allowances for the geographic area in which the services were rendered. The non-participating dentist may charge their usual fee for covered or non-covered services***. You will be responsible for the difference between the allowed amount, less the coinsurance and deductible, and the non-participating dentist's usual fee. Fees for non-covered services are your responsibility***.

In most cases, you must fill out and mail claim forms whenever you receive Out-of-Network services.

Benefit Percentage

This program pays a percentage of the cost for covered dental services based on Empire's Allowed Amount. You must pay the balance of these costs.

Covered dental services will be paid as follows:

- 80% for Diagnostic and Preventive services
- 80% for Basic services
- 50% for Major Services
- 50% for Orthodontics.

Note: Covered services charged by non-participating dentists are reimbursed up to Empire's Allowed Amount for Out-of-network services.

Deductible

A deductible is the amount of covered expenses that you must pay out of your own pocket before the benefits of coverage are payable. Each calendar year, for Diagnostic and Preventive, Basic and Major services you must pay a $50 individual and $100 family deductible before Dental PPO provides benefits for Out-of-Network services.

COVERED DENTAL SERVICES

DIAGNOSTIC AND PREVENTIVE

Diagnostic Services
In-Network Benefit Percentage 100%
Out of Network Benefit Percentage 80%
Periodic oral examination [1]
Emergency oral exam - only when performed in connection with accidental injury
Intraoral x-rays complete series [2]
Intraoral x-ray periapical first film [3,4]
Intraoral x-ray periapical additional film [4]
Intraoral x-ray occlusal film [4]
Bitewing x-ray single film [3,4]
Bitewing x-ray two films [3,4]
Bitewing x-ray four films [3,4]
Panoramic film [2]
Diagnostic casts

Preventive Services
In-Network Benefit Percentage 100%
Out of Network Benefit Percentage 80%
Prophylaxis adult [6]
Prophylaxis child [6]
Topical application of fluoride - child (excluding prophylaxis) [7]
Space maintainer fixed unilateral [8]
Space maintainer fixed bilateral [8]
Space maintainer removable unilateral [8]
Space maintainer removable bilateral [8]
Recementation of space maintainer
Sealant per tooth [9]

LIMITATIONS AND EXCLUSIONS ON DIAGNOSTIC, RADIOGRAPHIC & PREVENTIVE SERVICES

1. Oral exams are covered one (1) time per six months.
2. Full mouth series or panoramic x-ray studies are limited to one (1) time per thirty-six (36) months.
3. A maximum of 4 bitewing x-rays are limited to two (2) times in a twelve (12) month period.
4. Allowances for individual x-rays cannot exceed the allowance for full mouth series.
5. Cephalometric x-rays are available for orthodontia only, and when medically necessary as determined by Empire.
6. Adult prophylaxis and child prophylaxis are limited to not more than one (1) time in a six (6) month period.
7. The topical application of fluoride is limited to patients under age sixteen (16) and one (1) time in a six (6) month period.
8. Space maintainers are limited to patients up to the age of 12, one time per tooth.
9. Topical application of sealants - benefits will be provided for sealants only one (1) time per twenty-four (24) month period per tooth with a maximum of two (2) times per tooth and limited to primary and permanent molars only. This benefit is only available to covered persons under age 16.

BASIC SERVICES

Restorative Services *
In-Network Benefit Percentage 100%
Out of Network Benefit Percentage 80%

Amalgam one surface [(1)]
Amalgam two surfaces [(1)]
Amalgam three surfaces [(1)]
Amalgam four surfaces [(1)]
Resin-one surface, anterior [(1)]
Resin-two surfaces, anterior [(1)]
Resin-three surfaces, anterior [(1)]
Resin-four or more surfaces or involving incisal angle [(1)]
Resin-one surface, posterior [(1)]
Resin-two surfaces, posterior [(1)]
Resin-three surfaces, posterior [(1)]
Three or more surface metallic inlay
Onlay per tooth
Porcelain/ceramic - two surfaces inlay
Porcelain/ceramic - three surfaces inlay
Crown - resin (laboratory)
Crown - resin with high noble metal
Crown - resin with predominantly base metal
Crown - resin with noble metal
Porcelain crown/ceramic substrate
Crown - porcelain fused to high noble metal
Crown - porcelain fused to predominantly base metal
Crown - porcelain fused to noble metal
Crown (full cast) high noble metal
Crown - full cast predominantly base metal
Crown - full cast noble metal
Crown three-quarter cast metallic
Re-cement an inlay
Re-cement a crown
Simple extractions of erupted teeth
Prefab.stainless steel crown, primary tooth [(2)]
Prefab.stainless steel crown, permanent tooth [(2)]

* Benefits for single crowns and inlays shall be limited to those cases where individual teeth cannot be restored to function by fillings.

1. Amalgam, resin, acrylic, plastic or porcelain restorations on primary or permanent teeth are allowed one time per tooth per six (6) month period for the same surface.
2. Stainless steel crowns are limited to patients up to the age of 19.

BASIC SERVICES

Restorative Services (Continued) *
In-Network Benefit Percentage 100%
Out of Network Benefit Percentage 80%
Sedative filling (temporary filling)
Pin retention - per tooth, in addition to filling
Cast post and core in addition to crown
Prefab. post and core in addition to crown
Labial veneer - resin/lab
Labial veneer - (porcelain laminate) - lab
Temporary crown (fractured tooth)
Crown repair, by report

Endodontic Services
In-Network Benefit Percentage 100%
Out of Network Benefit Percentage 80%
Pulp cap-direct (excluding final restoration) [1]
Therapeutic pulpotomy (excluding final restoration) [2]
Anterior (excluding final restoration) [3]
Biscuspid (excluding final restoration) [3]
Molar (excluding final restoration) [3]
Apexification (per treatment visit) [4]
Apicoectomy
Apicoectomy - each additional root
Retrograde filling - per root
Root amputation - per root

* Benefits for inlays and crowns shall be limited to those cases where individual teeth cannot be restored to function by fillings.

1. Direct pulp capping is limited to one time per tooth for permanent teeth only. Indirect pulp capping is not covered.
2. Pulpotomy is allowed only one time per tooth and for patients under 14 years of age only.
3. All root canal therapy procedures includes six months of follow-up care. Retreatment is limited to one time after 36 months from initial treatment and only one tooth per lifetime.
4. Apexification is allowed only one time per tooth and for patients under 14 years of age not to exceed 3 treatment visits for a single tooth.

Benefits for labial veneers, pin retention and post and core are limited for replacement once every five years.

MAJOR SERVICES

Periodontic Services
In-Network Benefit Percentage 60%
Out of Network Benefit Percentage 50%
Gingivectomy or gingivoplasty – per quadrant [(1)]
Gingivectomy or gingivoplasty - per tooth[(1)]
Gingival flap procedure, including root planing per quadrant [(1)]
Osseous surgery (including flap entry and closure) per quadrant [(1)]
Osseous graft-single site (including flap entry and donor site) [(1)]
Osseous graft-multiple sites (including flap entry and donor sites) [(1)]
Pedicle soft tissue graft procedure [(1)]
Free soft tissue graft procedure (including donor site surgery)
Apically repositioned flap procedure
Periodontal scaling and root planing – four or more contiguous teeth [(2)]
Periodontal scaling and root planing - per quadrant, one to three teeth [(2)]
Periodontal maintenance procedures following active therapy [(3)]

1. Surgical periodontic procedures must be precertified and are limited to once in a 36-month period, twice in a lifetime per quadrant. This benefit is available for patients age 23 and older. However, when medically necessary and if supported by documentation supplied by the dentist and sufficient to Empire, the benefit will be available for patients under age 23.
2. Periodontal scaling and root planing is limited to one time per 18 month period. Coverage is for patients age 23 and older. However, when medically necessary and if supported by documentation supplied by the dentist and sufficient to Empire, the benefit will be available for patients under age 23. This procedure is not allowed on the same date of service as a periodontal surgical procedure performed in the same area of the mouth.
3. Periodontal preventive maintenance procedures will not exceed one time in a 3 month period and will exclude the benefit for prophylaxis in the same period. The total prophylaxis and periodontal maintenance procedures together will not exceed more than 4 services in a 12-month period.

MAJOR SERVICES

Prosthetic Services
In-Network Benefit Percentage 80%
Out of Network Benefit Percentage 70%
Complete upper denture
Complete lower denture
Immediate upper denture
Immediate lower denture
Upper partial-acrylic base (including any conventional clasps and rests)
Lower partial-acrylic base (including any conventional clasps and rests)
Upper partial-predominantly base cast base with acrylic saddles (including any conventional clasps and rests)
Lower partial-predominantly base cast base with acrylic saddles (including any conventional clasps and rests)
Removable unilateral partial denture-one piece predominantly base casting, clasp attachments-per unit (including pontics)
Adjust complete denture-upper
Adjust complete denture-lower
Adjust partial denture-upper
Adjust partial denture-lower
Repair broken complete denture base
Replace missing or broken teeth-complete denture (each tooth)
Repair acrylic saddle or base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth-per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture

MAJOR SERVICES

Prosthetic Services*
In-Network Benefit Percentage 60%
Out of Network Benefit Percentage 50%
Rebase complete upper denture
Rebase complete lower denture
Rebase upper partial denture
Rebase lower partial denture
Reline complete upper denture (chairside)
Reline complete lower denture (chairside)
Reline upper partial denture (chairside)
Reline lower partial denture (chairside)
Reline complete upper denture (laboratory)
Reline complete lower denture (laboratory)
Reline upper partial denture (laboratory)
Reline lower partial denture (laboratory)
Pontic-cast high noble metal
Pontic-cast predominantly base metal
Pontic-cast noble metal
Pontic-porcelain fused to high noble metal
Pontic-porcelain fused to predominantly base metal
Pontic-porcelain fused to noble metal
Pontic-resin with high noble metal

*Precertification with Empire is required before services can begin.

MAJOR SERVICES

Prosthetic Services (Continued) *
In-Network Benefit Percentage 60%
Out of Network Benefit Percentage 50%
Pontic-resin with predominantly base metal
Pontic-resin with noble metal
Inlay-metallic-two surfaces* *
Inlay-metallic-three or more surfaces* *
Crown-resin with high noble metal* *
Crown-resin with predominantly base metal* *
Crown-resin with noble metal* *
Crown-porcelain fused to high noble metal* *
Crown-porcelain fused to predominantly base metal* *
Crown-porcelain fused to noble metal* *
Crown 3/4 cast high noble metal* *
Crown-full cast predominantly base metal* *
Crown-full cast high noble metal* *
Recement bridge
Cast post and core in addition to bridge retainer
Prefabricated post and core in addition to bridge retainer
Bridge repair, by report

* Benefits must be precertified with Empire before services can begin.
* * Benefits for Prosthetic appliances shall be limited to those cases where individual teeth cannot be restored to function by fillings and are limited for replacement once every five years

MAJOR SERVICES

Oral Surgery [1]

In-Network Benefit Percentage 60%
Out of Network Benefit Percentage 50%
Removal of impacted tooth-soft tissue
Removal of impacted tooth-partially bony
Removal of impacted tooth-completely bony
Removal of impacted tooth-completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Tooth reimplantation and/or stabilization of accidentally evulsed or displace tooth and/or alveolus
Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)
Surgical exposure of impacted or unerupted tooth to aid eruption
Biopsy of oral tissue-hard [2]
Biopsy of oral tissue-soft [2]
Alveoloplasty in conjunction with extractions per quadrant
Alveoloplasty not in conjunction with extractions per quadrant
Excision of benign tumor lesion diameter up to 1.25 cm
Excision of benign tumor lesion diameter greater than 1.25 cm

1. For multiple surgical procedures performed at the same time and through the same incision, payment is made only for the procedure with the highest allowed amount. When done through different incisions payment will be made for each procedure.
2. Coverage for a biopsy of hard or soft tissue is limited to reimbursement of the surgical procedure and does not provide coverage for laboratory charges.

Oral Surgery (Continued)
In-Network Benefit Percentage 60%
Out of Network Benefit Percentage 50%
Removal of odontogenic cyst or tumor lesion diameter up to 1.25 cm
Removal of odontogenic cyst or tumor lesion diameter greater than 1.25 cm
Removal or nonodontogenic cyst or tumor lesion diameter up to 1.25 cm
Removal of nonodontogenic cyst or tumor lesion diameter greater than 1.25 cm
Removal of exostosis-maxilla or mandible
Incision and drainage of abscess-intraoral soft tissue (1)
Incision and drainage of abscess-extraoral soft tissue (1)
Removal of foreign body, skin or subcutaneous areolar tissue
Removal of reaction-producing foreign bodies-musculoskeletal system
Suture of recent small wounds up to 5cm
Suture-up to 5 cm
Frenulectomy (frenectomy or frenotomy) separate procedure
Excision of hyperplastic tissue per arch
Excision of pericoronal gingiva

Adjunctive General Services

Palliative treatment for dental pain
General anesthesia

Orthodontia
In-Network Benefit Percentage 50%
Out of Network Benefit Percentage 50%
Initial diagnostic workup including radiographs, models, and photographs
Orthodontic appliance insertion
Active treatment, per month
Orthodontic retention treatment

1. Incision and drainage of an abscess is not payable when done within 60 days following a covered endodontic, periodontic or surgical procedure.

Limitations And Exclusions

Benefits are not provided for:

- Services covered under any government program; federal, state, county or municipal law or under the laws of any other country or the United States (except Medicaid).
- Services covered under Workers' Compensation law, mandatory no-fault automobile insurance or similar legislation.
- Experimental or obsolete procedures that are neither of proven benefit nor generally recognized by the dental profession as effective.
- Elective or cosmetic treatment for any reasons.
- Replacement of misplaced or lost, damaged or stolen crowns, bridges, dentures, or other dental appliances.
- Implants or bridges involving implants.
- Treatment of Temporomandibular Joint Syndrome, which is medical in nature.
- Appliances or restoration used solely to increase vertical dimensions; (i.e. crown lengthening)
- Dental services rendered beyond the scope of the provider's license.
- Dental services or items not needed for proper dental care or not considered within the scope of normal good dental practice or which are inconsistent with the highest standards of the dental profession. No benefits will be provided for services where in the professional judgment of the Empire consultant dentist, a satisfactory result cannot be obtained.
- Dental services not listed in the contract or any rider in the contract.
- Services when there is more than one professionally acceptable method of treatment, coverage will be limited to the least costly method. If a covered person selects a more costly alternative, the participating dentist may charge the member the difference between the Empire Allowed Amount for that more costly alternative method and Empire's Allowed Amount for the least costly method. A non-participating dentist may charge his usual fee.
- Coverage will not be provided for the replacement of any teeth missing on the effective date of the covered person's coverage under this contract until a two-year waiting period has been completed.
- Services for multiple abutments for fixed bridgework.
- Services for any hospital charges when a covered dental service must be performed in a hospital. Empire will only cover the dental benefits specifically listed in the contract, when performed by a dentist in connection with such hospitalization.
- Services rendered prior to the covered person's effective date of coverage under the contract.
- Services for treatment for any disease, condition or injury sustained as a result of war, declared or undeclared.
- General anesthesia, unless the medical necessity for such general anesthesia is documented. Benefits for local anesthesia and analgesia are included in the payment to the covered person's provider for the covered service performed. Separate payment may be made for general anesthesia when approved by Empire in its sole discretion, only when administered by an anesthetist other than the covered person's own provider or provider's employees.
- Prescription and non-prescription drugs and medications.
- Miscellaneous tests and laboratory examinations.
- Orthognathic surgery.

- Appliances and bridgework used solely to splint periodontally involved teeth.
- Empire will not pay for any service if it is usually provided without charge, including but not limited to situations where a provider does not usually collect payment in the absence of insurance coverage. Coverage will not be provided for services rendered by a member of the covered person's immediate family.
- A prosthetic appliance (including crown, bridge, and denture) will be provided only once in every five years. The five year period will be measured from the date on which the existing appliance was last supplied whether such appliance was provided while covered under this contract or not. The appliance will not be replaced within the five year period even if the appliance is no longer in the possession of the covered person.
- A reline of a denture will be covered once in a 36-month period.
- An adjustment to a denture will be covered once in a twelve-month period.
- Benefits are not provided for gold foil restorations.
- Endodontic endosseious implants are not covered.
- Occlusal adjustment is not covered.

Additional limitations and exclusions for Orthodontia:

- Coverage is only available for treatment of functional malocclusion. The plan will pay 50% of the Empire Allowed amount up to a lifetime maximum allowance of $1,750. The benefit will be limited to 24 months of active treatment plus four retention visits. *Benefits are only available for covered dependent children up to age 19.*
- Coverage is only available for one course of treatment per lifetime per covered person.
- The maximum number of months for which benefits are available for treatment shall be reduced by the number of months of such treatment received ***before*** the effective date of this contract.
- No coverage is available for covered persons under the age of nine (9) years of age.
- No coverage is available for single tooth movement.
- No coverage is available for interceptive treatment.

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 allowable 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 (up to the Allowed Amount) for the remaining expenses 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 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:
  - ⇒ 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 contract 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, otherwise this rule should be ignored.
- If none of the previous rules apply, the health program that has covered the patient the longest will have primary responsibility.

CLAIMING BENEFITS

Benefits Precertification

Precertification helps you make an informed decision before treatment begins by letting you know **in advance** how much the program will pay for certain services. Precertification is required for crowns, fixed bridgework, periodontal surgery and all orthodontic services.

The precertification process requires your dentist to fill out a claim form with the *complete* treatment plan, **before treatment begins**. To reduce the processing time, please ask your dentist for your X-rays*. Either you or the dentist must send the treatment plan and X-rays to:

Empire BlueCross BlueShield
Dental Benefits Program
P.O. Box 791
Minneapolis, Minnesota 55440-0791

Our dental benefits professionals will process the treatment plan and send both the dentist and you a precertification form that identifies the covered services. You and the dentist will also receive (separately) an Explanation of Payment form that identifies services not covered by the program.

During the treatment plan, you can receive payment for the services rendered to date. In these situations, the dentist inserts the date(s) of the authorized service(s) on the precertification form. You and your dentist then sign and submit the precertification form to Empire BlueCross BlueShield. We will send the dentist payment for services rendered to date, and you and the dentist will receive a new, updated precertification form. We will repeat this process each time we receive and process a part of the treatment plan.

The precertification procedure for Orthodontic benefits varies slightly. In this instance, the dentist sends us an Orthodontics diagnosis and treatment plan. Once we approve the plan, we send the dentist an active billing form on a quarterly basis. The dentist fills in the service dates and sends us the form for payment.

*We routinely require x-rays for the following treatments: single crowns, inlays, onlays, fixed prosthetics, periodontics, and orthodontics.

Claiming Benefits

Participating PPO network dentists will file claims directly with Empire. If your dentist is in the network, the dentist will file the claim for you and we will send payment directly to your dentist based on Empire's allowed amount. A claim must be filed with Empire by the covered person or the non-participating provider of covered dental services. A non-participating provider may also choose to bill you directly. The covered person must then file the claim with Empire. When a claim is submitted for a covered dental service, the person must give Empire, or arrange for us to receive the following items which should be in English, or submitted with an English translation.

A completed claim form including any necessary reports and records must be submitted upon completion of services. ***This must be received by Empire within eighteen (18) months of the date that care was provided or the claim will not by honored or paid by Empire.***

You must complete a claim form when a dentist treats either you or an eligible dependent. When filling out a claim form, you complete the top portion of the claim form and the dentist completes the rest. You need to complete a separate claim form both for each patient and for each provider. Both you and the dentist must sign the bottom of the claim form. Once you have completed the claim form, send the form to:

Empire BlueCross BlueShield
Dental Benefits Program
P.O. Box 791
Minneapolis, Minnesota 55440-0791

Claim Review

Empire BlueCross BlueShield screens all incoming claim forms for completeness. We then code, number, register, and check claim forms for eligibility. Our examiners then review claims for coverage and issue either an approval or a rejection of benefits. You and your dentist will receive an Explanation of Benefit form from us showing the benefits we provided.

If you disagree with a claim disposition, you may request a review. You, or your duly authorized representative, must make the request in writing within 60 days. If we deny a claim, wholly or partly, you have the right to appeal our decision under the Employee Retirement Income Security Act of 1974 (ERISA). We will send you written notice of why the claim was denied. You will then have 60 days to submit a written request for review. Please submit your request to:

Claim Review Coordinator
Empire BlueCross BlueShield
Dental Benefits Program
P.O. Box 791
Minneapolis, Minnesota 55440-0791

We will send you a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, we can extend the review period for up to 120 days from the date we receive the appeal.

Be sure to include your current identification number, the claim number, and any pertinent information or comments. The request for claim review will incorporate any additional materials we receive. You will then receive written notification of the decision, explaining the basis for either upholding or modifying the original claim's disposition.

You may call **1-800-722-8879** for additional information. If you call, be sure to have your Empire BlueCross BlueShield identification number handy as well as any claim-related documents.

TERMINATION AND CONTINUATION OF COVERAGE

Termination of Coverage

Your Dental PPO coverage will continue unless terminated for any of the reasons set forth in the group contract. These include but are not limited to:

- your group terminates the contract on 60 days notice
- 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
- 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 if you or your group have otherwise engaged in fraud.
- Empire discontinues this class of coverage from the group market.

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, if your plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to your employer, or you becoming entitled to Medicare benefits (under Part A, Part B, or both, if applicable), 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 Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Client Services Representative.

HOW LONG WILL CONTINUATION COVERAGE LAST?

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 Wendy E. Patitucci, Director, Employee Policy and Practice for Research Foundation of the City University of New York 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 Wendy E. Patitucci, Director, Employee Policy and Practice for Research Foundation of CUNY, 230 West 41st Street, 7th Floor, New York, NY 10036 - 7296, 212-417-8300.

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.

he 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 heath 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 not 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.

Under State Law

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

Ending and Continuing Coverage

Your Employer/Plan Sponsor 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.

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
Appeal and Grievance Department
P.O. Box 791
Minneapolis, Minnesota 55440-0791

We will resolve complaints within the following time frames:

- Standard complaints. Within 30 days of receiving all necessary information.
- Expedited complaints. Within 72 hours of receiving all necessary information.

If you are not satisfied with our decision on your complaint, you may file a grievance under the procedures described in the pages that follow.

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 address above. 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 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 benefits. 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 you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal, and/or the right to file an External Appeal through the New York State Department of Insurance. If Empire's Medical Management Program does not make a decision within the appropriate time frame listed above, Empire will approve the service.

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.

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 the appropriate time frame listed above, 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

You may also 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.

<u>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.</u>

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 for a review of an adverse determination concerning an administrative decision not related to medical necessity. The types of decisions that may be reviewed through the grievance process include denials of a request for a referral to an out-of-network provider, benefit denials based on a specific limitation in the subscriber contract (e.g., no pre-certification was obtained), and complaint decisions where the member disagrees with Empire's findings.

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 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.

Decision on Grievances

Empire's notice of its Level 1 Grievance decision (whether standard or urgent) will include:

- The reasons for Empire's decision
- The clinical rationale, if appropriate, and
- Instructions on how to file a Level 2 Grievance if you are not satisfied with the decision.

Level 2 Grievances

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire. Empire must receive your request for a Level 2 Grievance by the end of the 60th business day after you receive our notice of determination on your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, 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, or a written statement that insufficient information was presented or available to reach a determination
- 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 1-800-722-8879 or write to the following address with the reason why you believe our 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 791
Minneapolis, Minnesota 55440-0791

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. 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 domestic relations order or 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 Area Office of Public Affairs for the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor

U.S. Department of Labor
PWBA Office of Public Affairs
Public Disclosure Room, Room N-1513
200 Constitution Avenue, N.W.
Washington, D.C. 20210

SUMMARY PLAN DESCRIPTION

Name of Plan:	Research Foundation of the City University of New York Group Health and Dental Plan
Policy Number:	174426
Name and Address of Employer:	Research Foundation, CUNY 230 West 41st Street, 7th Floor New York, NY 10036-7296
Who Pays for Plan:	You and your employer
Employer Identification Number:	13-1988190
Plan Number:	503
Plan Year End:	June 30
Plan Administrator Information:	Wendy E. Patitucci, Director Employment Policy and Practice Research Foundation, CUNY 230 West 41st Street, 7th Floor New York, NY 10036-7296 212-417-8300

Access to Information

In addition to calling Member Services for claim and benefit information, you can contact them for:

- 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 consumer report of grievances filed with the Insurance Superintendent
- Procedures that protect confidentiality of medical records and information
- A copy of Empire's Drug Formulary
- A directory of participating providers
- A description of our quality assurance program
- A notice of specific individual provider affiliations with participating hospitals
- Upon written request, specific written clinical criteria for determining if a procedure or test is medically necessary

For Members Who Don't Speak English

Empire will help members who speak languages other than English ask questions and file grievances in their first language. When you call Member Services, the operator will link you to an interpreter in your preferred language, who can facilitate the discussion. HealthLine is also equipped to provide assistance in most languages.

YOUR RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

HIPAA NOTICE OF PRIVACY PRACTICES

Effective July 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

EMPIRE HEALTHCHOICE ASSURANCE, INC.
(the "Company")
RIDER TO YOUR
CONTRACT OR CERTIFICATE
RE: ENROLLING A NEWBORN CHILD

This rider amends the requirements for enrolling a newborn child under your Contract, Certificate, or Group Plan as described below:

A. For a Member who has individual (for self only), employee\spouse, or parent\child (two person) coverage:
   1. He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within sixty (60) days after the date of birth.
   2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.
   3. If the Company does not receive enrollment notification within sixty (60) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form, provided that it is during the next open enrollment period after the birth or within the first year after the birth, which ever occurs first.
   4. If you do not switch to a parent\child, parent\children, or family contract and enroll your newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Contract, Certificate or Group Plan.

B. For a Member who has family or parent\children (more than two person) coverage:
   1. A newborn child, or a proposed adopted newborn, will be covered from the date of birth.
   2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.
   3. Coverage will still be effective from the date of birth for a newborn or a proposed adopted newborn if an enrollment form is received after sixty (60) days, and enrollment will still be retroactive to the date of birth.
   4. Any claims for a newborn or a proposed adopted newborn received after sixty (60) days will not be processed until the newborn or proposed adopted newborn is formally enrolled.

C. All of the terms, conditions, and limitations of the Contract, Certificate, or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.

Nancy L. Purcell
Corporate Secretary

Mark Wagar
President

R-Newborn Enrollment (EHCA) LGL 10037E
(9/07)

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 void 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 deleted and replaced with the following:

   If the insurance on an employee or member insured under the group contract ceases because of termination of (i) employment or of membership in the class or classes eligible for coverage under the contract or (ii) the contract, for any reason whatsoever, unless the contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group contract for at least three months shall be entitled to have issued to him by Empire without evidence of insurability upon application made to Empire within forty-five days after such termination, and payment of the quarterly, or at the option of the employee or member, a less frequent premium applicable to the form and amount of insurance, an individual contract of insurance. Empire may, at its option elect to provide the insurance coverage under a group insurance contract, delivered in this state, in lieu of the issuance of a converted individual contract of insurance. Such individual contract, or group contract, as the case may be, is hereafter referred to as the converted contract. The benefits provided under the converted contract shall be those required by subsection (f), (g), (h) or (i) of Section 3221 of the New York State Insurance Law, whichever is applicable and, in the event of termination of the converted group contract of insurance, each insured thereunder shall have a right of conversion to a converted individual contract of insurance.

   Written notice by your group given to you or mailed to your last known address, or written notice by Empire sent by first class mail to you at the last address furnished to Empire by your group, shall be deemed full compliance with the provisions of this subsection for the giving of notice.

   The converted contract shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group contract. If delivery of any individual converted contract is to be made outside this state, it may be on such form as Empire may then be offering for such conversion in the jurisdiction where such delivery is to be made.

   Notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

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 of 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. Termination and Nonrenewal. The provisions of the group contract and your evidence of coverage that describe the termination and nonrenewal of the group contract are deleted and replaced with the following:

   (A) The group may terminate the contract with Empire at any time upon 60 days notice. The group contract will be renewed and continued in force, except that Empire may nonrenew or discontinue coverage under the group contract based only on one or more of the following:

      (1) The group has failed to pay premiums or contributions in accordance with the terms of the group contract or Empire has not received timely premium payments.

      (2) The group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

      (3) The group has failed to comply with the material plan provision relating to employer contribution or group participation rules, as permitted under section four-thousand two hundred thirty-five of the Insurance Law of the State of New York.

      (4) Empire ceases to offer group or blanket policies in a market in accordance with this provision.

      (5) The group ceases to meet the requirements for a group under section four thousand two hundred thirty-five of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the contract is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.

      (6) Where Empire offers a group contract in a market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides or works in Empire's operating area.

      (7) Such other reasons as are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of ("HIPAA") the Act.

   (B) In any case where Empire decides to discontinue offering a particular class of group contract of hospital, surgical or medical expense insurance offered in the small or large group market, the contract of such class may be discontinued only if:

      (1) Empire provides written notice to the superintendent and to each contract holder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety (90) days prior to the date of discontinuance of such coverage; and

      (2) Empire offers to each contract holder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage currently being offered by Empire to a group in such market; and

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

(3) Empire acts uniformly without regard to the claims experience of those contract holders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.

(C) In any case in which Empire elects to discontinue offering all hospital, surgical and medical expense coverage in the small group market or the large group market, or both markets, in the state, health insurance coverage may be discontinued only if:

(1) Empire provides written notice to the superintendent and to each contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;

(2) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and

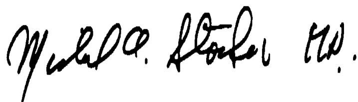
(3) Empire provides the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the market.

10. Any references in the group contract and your evidence of coverage which describe Empire's right to modify the group contract or your evidence of coverage are deleted and replaced with the following:

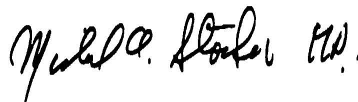
    At the time of coverage renewal only, Empire may modify the health insurance coverage for a group contract offered to a large or small group contract holder so long as such modification is consistent with New York State Insurance Law, and effective on a uniform basis among all small group contract holders with the contract form.

11. 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.