CERTIFICATE OF COVERAGE

empireblue.com

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.

Empire BlueCross BlueShield

An Anthem Company

Services provided by Empire HealthChoice Assurance, Inc., and/or Empire HealthChoice HMO, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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Empire BlueCross BlueShield

An Anthem Company

Vision Certificate of Coverage

BLUE VIEW VISION

Group Name:	RESEARCH FOUNDATION CUNY
Group Number:	174426
Effective Date:	January 1, 2020

The insurance evidenced by this certificate provides VISION insurance ONLY

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Welcome!

Thank you for choosing Empire Blue Cross and Blue Shield (Empire) for your vision care coverage. The following materials make up your *plan*:

- this booklet;
- your application, if any; and
- any endorsements or riders.

Your employer (also referred to as your *group*) has the following documents which are part of the terms of your *plan*:

- the *group contract*; and
- the group master application.

This certificate contains important information such as what vision care services are covered and how they will be covered. It replaces any older certificates issued to you for this vision plan.

Within this certificate *members* are referred to as “you” or “your”. Empire is referred to as “we,” “us” or “our.” All italicized words have special meanings that are defined in the Definitions section of this certificate.

Please review this certificate so you know where to find the information that you may need. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage. See the section Contact us for information on important phone numbers, addresses and websites.

Alan J. Murray
President and GM, Empire Blue Cross Blue Shield

Contact Us

If you have questions about your coverage or need assistance finding a Blue View Vision *network provider*, please contact us.

For Customer Service
Empire Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
(866) 723-0515

Visit us on-line
www.empireblue.com

Hours of Operation
Monday – Saturday:
8:30 a.m. to 11:00 p.m. Eastern Time

Sunday:
11:00 a.m. to 8:00 p.m. Eastern Time

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Schedule of Benefits

This schedule is an outline of your benefits. You need to refer to the entire *certificate* for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this *certificate* restricts or interferes with your right to select the vision care provider of your choice, but your benefits are reduced when you use a *non-network provider*. See the section How Your Benefits Work for more information.

COVERED SERVICES	COPAYMENTS/MAXIMUMS Network Providers	Non-Network Providers
Routine Eye Exam Limited to one exam Once every 24 months.*	$5 Copayment	Reimbursed up to $40
Prescription Lenses (Includes factory scratch coating, polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old when received from network providers). Limited to one set of lenses per member once every 24 months*. **Basic Lenses (Pair)**		
• Single Vision lenses	$0 Copayment	Reimbursed Up To $25
• Bifocal lenses	$0 Copayment	Reimbursed Up To $40
• Trifocal lenses	$0 Copayment	Reimbursed Up To $55
Frame Limited to one set of frames per member once every 24 months.*	$130 Allowance	Reimbursed Up To $45
Prescription Contact Lenses (traditional or disposable) **Note:** Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Schedule of Benefits.		
• **Elective Contact Lenses** Availability once every 24 months.*	$130 Allowance	Reimbursed Up To $105
• **Non-Elective Contact Lenses** Availability once every 24 months.*	Covered in full	Reimbursed Up To $210

* from the last date of service.

Laser Vision Correction Services
Participating LASIK/ photorefractive keratectomy (PRK) surgical centers offer a discounted rate. For *members* enrolled under this *plan*, you are responsible for any remaining charges.

Eligibility and Enrollment

Who is Eligible
This section will tell you who is eligible to enroll for coverage, as well as when you can enroll for coverage.

Subscriber. You are eligible to be a subscriber and have coverage under this plan if you are an employee of the group and meet the group's eligibility criteria. See your group for more information on specific eligibility requirements.

Dependents. You may enroll your eligible *dependents* for coverage under this *plan*. Your *dependents* are only eligible for coverage if they are one of the following:

- Spouse: Your spouse under a legally valid marriage.
- Domestic partner: Your domestic partner under a legally registered and valid domestic partnership. Check with your group's human resources or benefits department to see if your domestic partner is eligible for coverage under this *plan*.
- Children: Your or your spouse's or domestic partner's child by blood or by law up to age 26. This includes your natural children, stepchildren, legally adopted children, children placed for adoption, foster children or children for whom you are the legal guardian or have been court-ordered to provide coverage.

  Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the child's coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance, will remain covered while your insurance remains in force and your child remains in such condition. You have 31 days from the date of your child's attainment of the termination age to submit an application to request that the child be included in your coverage and proof of the child's incapacity. We have the right to check whether a child is and continues to qualify under this section.

  We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered subscriber and all other prospective or covered members as they pertain to eligibility for coverage under this certificate at any time.

Newborn and Adopted Child Coverage. If you have a newborn or adopted newborn child, and we receive notice of such birth within 30 thereafter, coverage for your newborn starts at the moment of birth; otherwise, coverage begins on the date on which we receive notice. Your adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoptions has not been revoked. If you have individual or individual and spouse coverage, you must notify us of your desire to switch to parent and child/children or family coverage and pay any additional premium within 30 days from the date of birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which we receive notice, provided that you pay any additional premium when due.

Enrollment

Initial Enrollment. Your *group* will have an initial enrollment period for newly eligible employee and their *dependents* to enroll for coverage. You may need to meet a waiting period established by the *group* before you can enroll for coverage. See your *group's* human resources or benefits department to determine if there are any waiting periods.

If you or your *dependents* do not enroll during the initial enrollment period you will only be able to enroll during and open enrollment or special enrollment period. Keep reading for more information on open and special enrollment periods.

Open Enrollment. At least once a year your employer will hold an open enrollment period. During the open enrollment period you and your *dependent*s can enroll for coverage. If you do not enroll during the open enrollment period, you may have to wait until the next open enrollment period, unless you qualify for a special enrollment period. See below for more information on special enrollment.

Special Enrollment. Your plan elections chosen during initial or open enrollment are intended to remain the same until the next open enrollment period. However, there may be times when you or your *dependent*s can enroll for coverage

outside of the open enrollment period. This is allowed if you have certain qualifying events that happen. Qualifying events are:

- You or your *dependents* did not previously enroll for coverage because you had coverage under another group plan (including COBRA or other continuation coverage) and have since become ineligible for that plan. You must request enrollment within 31 days of this qualifying event.
- You have a change in the number of *dependents* due to marriage, birth, adoption, court order, legal guardianship, or death. You must request enrollment within 31 days of this qualifying event.
- You or your *dependents* lost coverage under Medicaid or a Children's Health Insurance Program (CHIP), or became eligible for a subsidy (state premium assistance program) under Medicaid or CHIP. You must request enrollment within 60 days of this qualifying event.

Gap in Coverage. If your coverage terminates and you become eligible for coverage again and reenroll within 13 weeks of losing coverage, all benefit maximums and frequencies will continue to apply during the current benefit period.

Notice of Changes in Eligibility. You must tell your group if there are any changes that will affect your or your *dependent*'s eligibility. This includes a change in address or a change in the number of your *dependents*. The *group* is then responsible to notify us of any changes according to the terms of the *group contract*. If your *group* fails to notify us of your changes in eligibility, it does not obligate us to pay for your vision care.

Your Effective Date. Your coverage begins at 12:01 a.m. Eastern Time on the *effective date*. Your *effective date* and enrollment requirements are described in the *group contract*. See your employer's human resources or benefits department for more information on your specific *effective date* under this *plan*.

Statements and Forms. *Subscribers* or applicants for membership shall complete and submit applications, questionnaires or other forms or statements the *plan* may reasonably request.

Applicants for membership understand that all rights to benefits under this *certificate* are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a *member* may result in termination of coverage as provided in the Termination and Continuation of Coverage section. We will not use a statement made by a *member* to terminate the *member's* contract after two years have passed since the enrollment date. This does not apply, however, to fraudulent misstatements.

Delivery of Documents. We will provide an identification card and a *certificate* for each *subscriber.*

Termination and Continuation Of Coverage

Except as otherwise provided, your coverage will terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your group's agreement with us and your specific circumstances, such as whether premium has been paid in full:

If Your Group Cancels Coverage. Your coverage will end if your employer cancels coverage or on the date the *group contract* between us and your employer ends.

If You Cancel Your Coverage. If you want to cancel your or your *dependent's* coverage you need to notify your *group*. See your *group's* human resources or benefits department for more information on how to cancel your coverage. If you cancel, your *group* will be responsible to notify us in writing of the cancellation.

If You or Your Dependents Are No Longer Eligible. Coverage will end when you and/or your *dependents* no longer meet the eligibility requirements as outlined under the section Eligibility and Enrollment. When you or your *dependents* are no longer eligible, the date coverage ends is determined by the *group* in accordance with its eligibility requirements. For spouses in cases of divoirce, coverage will end on the date of the divorce. Upon the subscriber's death, coverage will terminate unless the subscriber has coverage for dependents. If the subscriber has coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.

Fraud, Intentional Misrepresentation, Misuse of an ID Card. We will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. Subject to the incontestability provision, we will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. We may also cancel your coverage for other types of fraud, such as if you allow any other person to use your ID card to obtain benefits, or if you use another *member's* ID card (including one of your *dependent's* ID card) to obtain benefits. You will be held liable for any payments we make as a result of fraud. For any fraud or intentional misrepresentation, coverage will end on the date we send the written notice of cancellation.

If Your Group Does Not Pay the Premium. We must receive the premium no later than the end of the grace period for your coverage to remain in force. If your employer does not pay your premium by the end of the grace period as stated in the *group* contract, we may cancel this coverage.

If You Fail to Pay the Premium. If you fail to pay or fail to make satisfactory arrangements with the *group* to pay your portion of the premium, coverage will end as of the last date for which premium was paid.

We Cease to Offer This Coverage. If we cease to offer coverage in the group employer market, we will cancel your coverage in accordance with the terms and conditions of state laws.

Continuation of Coverage
COBRA Continuation of Coverage. Your employer is subject to COBRA if they have more than 20 employees. COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

COBRA coverage is available to you and your *dependents* for 18 months for the following events:

- You lose coverage due to a reduction in working hours, a layoff, or strike.
- You lose coverage because your employment ends (for voluntary or involuntary loss, except for gross misconduct).

COBRA coverage is available to you and your *dependents* for 29 months for the following events:

- You or your *dependent* was disabled when coverage ended or within 60 days after the coverage ended. However, you or your *dependent* must continue to be disabled after 18 months has passed. The Social Security Administration must determine if you are disabled.

COBRA coverage is available to your *dependents* for 36 months for the following events:

- Your death.
- You become eligible for Medicare in the 18 months before an event listed above.
- You divorce or separate from your spouse.
- Your dependent children no longer qualify as dependents.

You must notify your employer within 60 days if you or your dependents wish to continue coverage under COBRA after an event. Once notified, your employer will provide the information on how coverage under COBRA may continue, and must give us notice within 30 days of the event that you wish to continue coverage. Contact your employer for more information.

How Continuation of Coverage Ends. Your continuation of coverage ends when the time period that you qualified for runs out. However, coverage may end before that time if one of the following occurs:

- The *group contract* between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium (subject to the grace period).
- You tell us in writing to cancel your coverage.
- The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for COBRA if the following occurs:

- You are eligible for coverage with another group. However, if your COBRA plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.
- You get Medicare
- Your coverage was extended to 29 months and you are now no longer disabled.

How Your Benefits Work

This section tells you how we set the payment amount for *covered services*. It will also tell you more about what you pay out-of-pocket for *covered services*, as well as how your choice of *provider* may affect your out-of-pocket costs. The portion you must pay for *covered services* is stated in the Schedule of Benefits at the beginning of this *certificate*.

Choosing a Provider
Please read the following information so you will know from whom or what group of providers vision care may be obtained.

> **Important Note:** We do not restrict or interfere with your right to select the *provider* of your choice, but your benefits are reduced when you use a *provider* who is not a *network provider*.

Network Providers**.** We have a network of vision care providers for you to use. We call them network providers, because they have agreed to take part in our Blue View Vision network. They have agreed to provide *covered services* to you for a negotiated rate. *Covered services* you receive from a network provider are considered In-Network care.

> **IMPORTANT:** If you opt to receive optometric services or procedures that are NOT *covered services* under this *plan*, a *network provider* may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with optometric services or procedures that are not *covered services*, the *provider* should provide you with a treatment plan that includes each anticipated service or procedure to be given and the estimated cost of each service or procedure. To fully understand your coverage, you may wish to review your *certificate*.

Non-Network Providers. Non-network providers are vision care providers that did not agree to participate in our Blue View Vision network. They have not agreed to a negotiated rate and do not have a provider contract with us. Using a non-network provider will typically increase your out of pocket costs. *Covered services* you receive from non-network providers are considered Out-of-Network care.

Please call us or visit our website listed in the Contact Us section for help in finding a *network provider*.

Benefit Maximums, Allowances and Frequency Limits
The amount we pay for your benefits is subject to your benefit maximums, allowances and frequency limits. We will not pay for vision care services that go over your benefit maximums or allowances, or for services that are received more than the allowed frequency limits. Benefit maximums, allowances, and frequency limits are stated in the Schedule of Benefits at the beginning of this *certificate*.

Your Cost Share Requirements
We will pay up to the *maximum allowable amount* for *covered services*. You may be required to pay a part of the *maximum allowable amount*. This is called your cost share amount. *Copayments* are an example of a cost share amount. See the Schedule of Benefits to help determine your cost share amount for *covered services*.

Your cost share amount may vary depending on whether you receive vision care from a *network* or *non-network provider*. You may be required to pay higher cost sharing amounts when using *non-network providers*.

We will not pay for vision care that is not covered under this plan. You are required to pay all charges for vision care that is not covered. Vision care received after you have met any benefit maximums or benefit frequency limits are also not covered.

Covered Services

This section describes the *covered services* available under your vision care benefits, when received by a *provider*. All *covered services* are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the *certificate*.

Routine Eye Exam. Your *plan* covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee. Your plan covers a refraction in conjunction with an eye exam. A refraction is your prescription based on your eye exam. *Network providers* should not bill the refraction separately from the routine exam.

Eyeglass Lenses. You have a choice in your eyeglass lenses. Eyeglass lenses include factory scratch coating at no additional cost. Your *dependent* children under 19 may also receive polycarbonate and photochromic eyeglass lenses at no additional cost when received from a *network provider*.

Covered eyeglass lenses include plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)

Frames. You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

Contact Lenses. This plan covers elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both. The contact lens *allowance* may be carried forward to use during another service date. The Schedule of Benefits lists the contact lens *allowance* under this *plan*.

> **Note:** Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the Schedule of Benefits.

Elective Contact Lenses. Elective contact lenses are contacts that you choose for appearance or comfort.

Non-Elective Contact Lenses. Non-elective contact lenses are prescribed by your provider for diagnoses listed below:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
- Keratoconus-unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
- High Ametropia-unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- Anisometropia-when one eye requires a much different prescription than the other eye.

Important Note: We will not reimburse for non-elective contact lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

LIMITATIONS - Coverage is NOT provided for:

- **Non-licensed vision care providers**. Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.
- **Eye surgery**. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- **Missed or cancelled appointments**. We will not pay for appointments a member has missed or cancelled.
- **Excess amounts**. Any amounts in excess of the maximum benefits stated in this *certificate*.
- **Orthoptics**. Orthoptics or vision training and any associated supplemental testing.

- **Services or supplies combined with discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement.
- **Not specifically listed**. Services not listed in the Covered Services section of this *certificate*.
- **Hospital care**. Inpatient or outpatient hospital vision care.
- **Sunglasses**. Sunglass lenses or accompanying frames.
- **Non-prescription lenses**. Any non-prescription lenses, eyeglasses or contacts, or plano lenses or lenses that have no refractive power.
- **Lost or broken lenses or frames**. Any lost or broken lenses or frames, unless you have reached a new benefit period.
- **Premium contact lenses fittings**. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Cosmetic Options**. Cosmetic lens options not specifically listed

Additional Options. Benefits are available for additional services in accordance with the Additional Savings Program. For additional information on available discounts please contact your *network provider* or call customer service.

Exclusions

We will not pay for services incurred for, or in connection with, any of the items below.

- **Voluntary payment**. Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Work-related**. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those condition pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
- **Government treatment**. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Services of relatives**. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.

How to Submit a Claim

This section describes how you submit a claim and what information you should include on your claim. When you receive care from a *network provider*, you do not need to file a claim. The *network provider* will do this for you. However, if you receive vision care from a *non-network provider*, you will need to submit a claim to us.

Notice of Claim. Claims for services must include all information designated by us as necessary to process the claim, including, but not limited to, member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information.

Claim Forms. We will provide claim forms within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to submit. If you do not receive the claim form within 15 days of your notice, you may send us other written proof of your loss instead, such as an itemized bill from your *provider*. To make it easier to process your claim, the other proof of loss should include the following:

- the date of service
- the patient's name, date of birth, and identification number
- the type and place of service
- your signature and the provider's signature

Proof of Loss. Written proof of claim satisfactory to us must be submitted to us within 120 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the benefit or claim amount will not be reduced or denied if you show that it was not reasonably possible to give notice within that period and that you sent proof as soon as reasonably possible. In any case, we request that the proof required must be sent to us no later than one year following the 120 day period specified, unless you were legally incapacitated.

Notice of claim, claim forms and other proof of loss can be sent to the following address:

Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

Time of Payment of Claims. We will pay claims immediately once we receive written proof of your claim, but not later than 39 days after we receive your proper written proof of loss.

Payment of Claims. Where our obligation to pay a claim is reasonably clear, we will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If we request additional information, we will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

General Provisions

Entire Contract. The law of the state in which the *group contract* was issued will apply unless otherwise stated herein.

Entire Contract – Changes. Your *plan* is the entire contract of insurance. Your *plan* is made up of this *certificate*, your application (if any), and any amendments. In addition, your employer has the *group contract* and the group master application, which are also part of your *plan*. No agent of the plan is authorized to change the form of content of this *plan* or waive any of its provisions. Any changes to the *plan* must be endorsed by an executive officer. All statements made by you or your employer shall be deemed representations and not warranties. No written statement made by you will be used in any context to deny a claim unless a copy of the statement is furnished to you, your beneficiary or personal representative.

Incontestability. The validity of this *plan* will not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. No statement made by you or your *dependents* relating to you or your *dependent's* insurability will be used to contest the validity of this *certificate* unless the statement is contained in a written instrument signed by your or your *dependents*.

Physical Examinations. We may have you examined as reasonably needed while we are deciding to pay a claim.

Change of Beneficiary. You have the right to choose your own beneficiary.

Independent Contractors. *Providers* are not our agents or employees. They do not have the ability to waive or alter your *plan*. We are not responsible for any damages or injuries as a result of receiving care from any *provider*.

Right of Recovery. When we overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person we paid, or another plan. We may deduct any overpayment from pending or future claims.

Benefits not Transferable. You are the only person able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

Legal Actions. No action at law or in equity shall be brought to recover on this *plan* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Coordination of Benefits. We consider this *plan* primary in all circumstances.

Grace Period. Your *group* is responsible to pay premiums on your behalf. After the first premium payment, your *group* has a grace period of 31 days to pay any *premium* due. During the grace period, your coverage will continue in force unless your *group* has given us written notice to cancel the coverage in accordance with the terms of the *group contract*. Your *group* is responsible to pay any premium to the plan. However, you may be required to pay a portion of the premium to your *group*. See your *group* for more information on premiums.

Conformity with the Law. Any provision of this *plan* which is in conflict with the laws of the state in which the *group contract* is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications. We may change this *plan*, including the premiums, at any time by providing notice to the *group* at least 30 days before the change takes effect

Notice of Privacy Practices. We maintain a privacy program designed to protect your health information consistent with applicable law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place that are designed to protect your information. We are required by law to provide individuals with notice of our legal duties and privacy practices. To obtain a copy of this notice, call us or visit the website listed in the Contact Us section of this *certificate*.

Reservation of Discretionary Authority
The following provision only applies where the interpretation of this *certificate* is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq. The *plan*, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, has complete discretion to determine the

administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. However, a *member* may utilize all applicable grievance and appeals procedures.

The *plan*, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the *certificate*. This includes, without limitation, the power to construe the *group contract*, to determine all questions arising under the *certificate*, to resolve member grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this *certificate*. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the *group contract* the *certificate*, provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Grievance and Appeals

Grievances. Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers. **Note**: Empire plays all claims under this *plan* without conducting a medical necessity review.

Filing a Grievance. You can contact us by phone at (866) 723-0515 or in writing to file a grievance. You or a person you authorize has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgement letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances depending on the nature of your inquiry.

Grievance Determination. Qualified personnel will review your grievance, or it if is a clinical matter, a licensed, certificated or registered health care professional will look into it. We will decide the grievance and notify you within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your grievance.
Post-Service Grievances: (A request for a service or treatment that has already been provided)	In writing, within 30 calendar days of receipt of your Grievance.
All Other Grievances: (that are not in relation to a claim or request for services)	In writing, within 30 calendar days of receipt of your grievance.

Grievance Appeals. If you are not satisfied with the resolution of your grievance, you or you authorized representative may file an appeal by phone or in writing. You have up to 60 business days from receipt of the grievance determination to file an appeal.

When we receive your appeal, we will mail an acknowledgement letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your appeal and indicate what additional information, if any, must be provided.

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

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of your appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of your appeal.
All Other Grievances: (that are not in relation to a claim or request for service.)	30 business days of receipt of all necessary information to make a determination.

If you remain dissatisfied with our appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If you need assistance filing a grievance or appeal, you may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

External Appeals

A. Your Right to an External Appeal
In some cases, you have a right to an external appeal of a denial of coverage. If we hae denied coverage on the basis that a service is not medically necessary (including appropriateness, health care setting, level of care, or effectiveness of a *covered service*) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the state to conduct these appeals.

In order for you to be eligible for an external appeal, you must meet the following two (2) requirements:
- The service, procedure, or treatment must otherwise be a *covered service* under this *certificate* and
- In general, you must have received a final adverse determination through our internal appeals process. But you can file an external appeal even though you have not received a final adverse determination through our internal appeal process if:
    - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
    - You file an external appeal at the same time as you apply for an expedited internal appeal; or
    - We fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violations was for good cause due to matters beyond our control and the violation occurred during an ongoing good faith exchange of information between you and us.

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary
If we have denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you meet the requirements for an external appeal in paragrapgh A above.

C. Your Right to Appeal a Determination that Service is Experiemental or Investigational
If we have denied coverage on the basis that the service is an experimental or investigational treatmet (including clinical trials and treatments for rare diseases), you must satisfy the two (2) requirements for an external appeal in paragraph A above and your attending physician must certify that your condition or disease is one for which:
1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one (1) of the following;
1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you that the requested service, the requested service is likely to benefit

you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In additional, your attending physicial must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

D. The External Appeal Process
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issues through our internal appeal process or our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at (800) 400-8882. Submit the completed application to the New York State Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal the State will forward the request to a certified external appeal agent.

You can submit additional documentation with your external appeal request. If the external appeal agent determines the the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below), we do not have a right to reconsider our decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or us. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If Your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment we will provide coverage subject to the other terms and conditions of this *certificate*. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this *certificate* for non-investigational treatments provided in the clinical trial.

The external appeal agent's decision is binding on both you and us. The external appeal agent's decision is admissible in any court proceeding.

We will charge you a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

E. Your Responsibilities
It is your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the New York State Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New Yor State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Statement of ERISA Rights

As a member of this plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally does not apply to church plans or to governmental plans, such as plans sponsored by city, county, or statement governments, or public school systems. Check with your *group* to determine if your plan is subject to ERISA.

As part of your rights, you may examine, without charge, at your *group's* plan administrator's office or at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports) and plan descriptions. You may obtain copies of all plan documents and other plan information by writing to your *group's* plan administrator. The administrator may make a reasonable charge for the copies.

Plan Fiduciaries. In addition to creating rights for plan members, ERISA imposes duties upon the people who are responsible for the operation of your employee benefit plan. The people who operate your plan are called "fiduciaries" of the plan. They have a duty to operate the plan prudently and in the interest of you and other plan members.

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA Rights. Under ERISA, there are steps to enforce the rights listed above. For instance:

- If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the administrator).
- If you have a claim for benefits for an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state of federal court.
- If 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 decides who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay the court costs and fees. If you lose, the court may order you to pay these costs and fees. You may lose if, for example, the court finds your claim to be frivolous.

Assistance. If you have questions about your plan, contract your *group*. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor. You can find the contact information in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Definitions

This section defines terms that have special meanings. If a word or phrase has a special meaning or is a title, it will be italicized. The word or phrase is defined in this section or at the place in the text where it is used.

Allowance. A dollar amount available to apply towards materials or services.

Certificate. This summary of the terms of your benefits. It is attached to and is a part of the *group contract* and is subject to the terms of the *group contract*.

Copayment (or Copay). A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

Covered Services. Services and supplies or treatment as described in the *certificate* which are performed, prescribed, directed or authorized by a *provider*. A *covered* service is incurred on the date the service, supply or treatment was provided to you. To be a *covered service* the service, supply or treatment must be:

- Within the scope of the license of the *provider* performing the service;
- Rendered while coverage under this *certificate* is in force;
- Within the *maximum allowable amount*;
- Not specifically excluded or limited by the *certificate*;
- Specifically included as a benefit within the *certificate*.

Dependent. A member of the *subscriber's* family who is eligible for coverage under the *plan* as described in the Eligibility and Enrollment section of this *certificate*.

Effective Date. The date when your coverage begins under this *certificate*.

Group. The employer that has entered into a *group contract* with us to provide the benefits of the *plan***.**

Group Contract. The contract issued by us to the *group* as a means of providing certain benefits to the *group's* employees and eligible *dependents*.

Maximum Allowable Amount. The maximum amount allowed for *covered services* you receive based on the fee schedule. The maximum allowable amount is subject to any copayments, coinsurance, limitations or exclusions listed in this *certificate*.

For a *network provider*, the maximum allowable amount is equal to the amount that constitutes payment in full under the *network provider's* participation agreement for this product. If a *network provider* accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the maximum allowable amount.

For a *non-network provider* who is a physician or other non-facility *provider*, even if the *provider* has a participation agreement with us for another product, the maximum allowable amount is the lesser of the actual charge or the standard rate under the participation agreement used with *network providers* for this plan.

The maximum allowable amount is reduced by any penalties for which a *provider* is responsible as a result of its agreement with us.

Last Date of Service – The period of time in which benefits are tracked. The member must wait until the specific interval from the last date of service to receive covered services as listed in the Schedule of Benefits.

Member. A *subscriber* or *dependent* who has satisfied the eligibility conditions; applied for coverage; been accepted by *us for coverage*; and for whom premium payment has been made. *Members* are sometimes called "you" and "your."

Network Provider. A *provider* who has entered into a contractual agreement or is otherwise engaged by us to provide *covered services* and certain administration functions for the network associated with this *plan*.

Non-Network Provider. A *provider* who has not entered into a contractual agreement with us for the network associated with this*plan*.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this *certificate*, your application (if any), any endorsements, the *group contract,* and the group master application.

Provider. A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that we approve. This includes any *provider* rendering services that are required by applicable state law to be covered when rendered by such *provider*.

Subscriber. The employee that has enrolled and been accepted for coverage under this *plan*.

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bengali
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Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи

звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu
ۓپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Yiddish
רופט די מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. (TTY/TDD:711)

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

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEATH BENEFITS. 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 health care operations: We use and share PHI for our health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber or your plan for payment purposes.
- We may share PHI with your health care providers so that the provider may treat you.
- We may use PHI to review the quality of care an services you get.
- We may use PHI to provide you with care management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may use your publicly and/or commercially available data about you to provide you with information about available health plan benefits and services.
- We may also use and share PHI directly or indirectly wit health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit empireblue.com/health-insurance/about-us/privacy for more information.

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.

You may have an opportunity to receive email communications involving limited PHI such as welcome materials. We will obtain your consent before initiating these email communications.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, ,we must get your OK in writing first, We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice also require your written OK. You always have the right to revoke any written OK you provide,

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 for other types of activities including:,

- Health oversight activities.

- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents).

- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety.

- Special government functions, for Worker's 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; and

- 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. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to received your PHI – unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

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.

Genetic Information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, Ethnicity and Language: We may receive race, ethnicity and language information about you and protect this information as described in this Notice. We may use this information in various health care operations, which include identifying health care disparities, developing care management programs and educational materials and providing interpretation services. We do not use race, ethnicity and language information to perform underwriting rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of you PHI through email. It is important to note that there is some level of risk that you PHI could be read or accessed by a third party when it is sent by unencrypted email. We will confirm that you want to receive PHI by unencrypted email before sending it to you.

- 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. Customer Service representatives 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.

- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent to use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Empire BlueCross BlueShield (Empire), Empire does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Empire does not have to agree to your restriction.

How we protect information

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

We have to keep your PHI private. If we believe you PHI has been breached, we must let you know.

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 securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These 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 and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not pre-empt, 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.

Contacting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be contacted by phone, just let the caller know, and we won't reach out this way anymore or call 1-844-203-3796 to add your phone number to our Do Not Call list.

Complaints

If you think we have not protected your privacy, you can file a complaint with us at the Customer Service phone number printed on your ID card. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services, Office for Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. 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. Representatives 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.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

STATE NOTICE OF PRIVACY PRACTICES

As mention in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

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.

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. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, 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.