



**GENERAL
INFORMATION
& BOOK
EMPIRE PLAN
CERTIFICATE
AMENDMENTS**

For Employees of the State of New York
represented by **Civil Service Employees Association**
and for their enrolled Dependents,
COBRA enrollees with their benefits
and *Young Adult Option Enrollees*

JANUARY 2010

State of New York Department of Civil Service
Employee Benefits Division
<https://www.cs.state.ny.us>

**Keep these amendments with
your August 1, 2001 New York
State Health Insurance Program
General Information Book and
Empire Plan Certificate.**

Pages in your Book/Certificate and
later Certificate Amendments have
consecutive numbers.

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The policies and benefits described in this booklet are established by the State of New York through negotiations with State employee unions and administratively for non-represented groups. Policies and benefits may also be affected by federal and state legislation and court decisions. The Department of Civil Service, which administers the New York State Health Insurance Program (NYSHIP), makes policy decisions and interpretations of rules and laws affecting these provisions.

Where this document differs from your August 1, 2001 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports* and *Certificate Amendments*, this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Your Spouse

Add the following as the second paragraph of "Your Spouse" under "Your Dependents" in the "Who is Eligible" section on page 4 of your NYSHIP General Information Book.

In addition, persons who are party to a same sex marriage validly entered into in a jurisdiction where same sex marriage is permitted are eligible for spousal benefits.

Substitute the following for the paragraph entitled "Note on Tax Implications:" under "Or your domestic partner" in the "Who is Eligible" section on page 4 of your NYSHIP General Information Book.

Domestic Partner

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of health insurance benefits is treated as income for tax purposes. Ask your tax consultant how enrolling your domestic partner will affect your taxes.

Substitute the following for "Medical leave for students age 19 or over" under "3. Your child age 19 years or over who is a full-time student" in the "Who is Eligible" section on page 6 of your NYSHIP General Information Book.

Medical leave for students age 19 or over

If your dependent child is granted a medical leave by the school or changes from full-time to part-time status due to serious injury or illness, health insurance coverage will continue for a maximum of one year from the month in which the student status changes, plus any time before the start of the next regular semester. You must provide written documentation from the school and/or doctor.

Substitute the following for the first sentence of the first paragraph of "5. Disabled dependents" under "Your dependents" on page 7 of your NYSHIP General Information Book.

Disabled Dependents

Your unmarried dependent children age 19 or over who are incapable of self sustaining employment because of mental illness, developmental disability, mental retardation as defined in the Mental Hygiene Law or physical handicap who became incapacitated before the age at which dependent coverage would otherwise be terminated are eligible.

Add the following immediately after "Proof of eligibility" on page 7 of your NYSHIP General Information Book.

Young Adult Option

The Young Adult Option allows the Young Adult child of a NYSHIP enrollee to purchase individual health insurance coverage through NYSHIP when the Young Adult does not otherwise qualify as a dependent under NYSHIP.

Cost

The Young Adult or his/her parent must pay a separate premium for the Young Adult Option. There will be no employer contribution by the State toward the cost of the Young Adult Option. The Young Adult or his/her parent are required to pay the full cost of premium for individual coverage for the NYSHIP option selected for coverage.

Eligibility

In order for a Young Adult to be eligible to enroll in NYSHIP under the Young Adult Option, the Young Adult must:

1. be a child, adopted child, or step-child of a NYSHIP enrollee (including those enrolled under COBRA);
2. be age 29 or younger;
3. be unmarried;
4. not be insured by or eligible for coverage through the Young Adult's own employer-sponsored health plan, whether insured or self-funded, provided that the health plan includes both hospital and medical benefits;
5. live, work or reside in New York State or the insurer's service area; and
6. not be covered under Medicare.

Eligibility for NYSHIP enrollment under the Young Adult Option ends when one of the following occurs:

1. the Young Adult voluntarily terminates coverage;
2. the Young Adult's parent is no longer enrolled in NYSHIP;
3. the Young Adult no longer meets the eligibility requirements for the Young Adult Option as outlined above;
4. the NYSHIP premium for the Young Adult is not paid in full within the 30-day grace period.

Termination of coverage under the Young Adult Option does not cause a "qualifying event;" therefore, the Young Adult has no right to federal COBRA coverage or State continuation coverage when the Young Adult coverage ends.

Available Coverage

A Young Adult is entitled to the same health insurance coverage as his/her parent provided the Young Adult lives, works or resides in New York State or the insurer's service area. Additionally, NYSHIP will permit a Young Adult to enroll in any other NYSHIP option for which the Young Adult otherwise qualifies for enrollment under NYSHIP rules. A Young Adult may:

1. Enroll in The Empire Plan regardless of the parent's option;
2. Enroll in the same HMO as the parent if the Young Adult lives, works or resides in the HMO's service area or in New York State; or
3. Enroll in a NYSHIP HMO that the parent is not enrolled in if the Young Adult lives, works or resides within the HMO service area.

Enrollment Rules

Either the Young Adult or his/her parent may enroll the Young Adult in the Young Adult Option, and either may elect to be billed for the Young Adult's NYSHIP premium.

A Young Adult has the following opportunities to be enrolled in the Young Adult Option:

1. **When the Young Adult Would Otherwise Lose Coverage Due to Age**

Coverage may be elected within 60 days of the date that the Young Adult otherwise would lose eligibility for coverage, as his/her parent's dependent, due to age. Coverage is retroactive to the date that the Young Adult lost coverage due to age. This is the only circumstance in which the Young Adult Option will be effective on a retroactive basis.

2. **During the Young Adult Option Open Enrollment Period**

Coverage may be elected by an eligible Young Adult at any time during calendar year 2010. Beginning in 2011 coverage may be elected during the Young Adult Option annual 30-day open enrollment period. Coverage will be effective no later than 30 days after NYSHIP receives written notice of the election and payment of the first month premium.

3. **When the Young Adult is Newly Qualified Due to a Change in Circumstances**

Coverage may be elected within 60 days of the date that the Young Adult newly meets the eligibility requirements for the Young Adult Option, such as loses coverage through his/her employer; moves his/her residence into New York State; or gets divorced. It is possible for a Young Adult to elect coverage under this option on multiple occasions due to changes in the Young Adult's eligibility over time. Coverage will be effective prospectively, no later than 30 days after NYSHIP receives written notice of the election and payment of the first monthly premium.

Add the following after "Exceptions for new dependents" in the "Coverage: Individual or Family" section on page 10 of your NYSHIP General Information Book.

Exception: CHIP and Medicaid

Exception for Children's Health Insurance Program (CHIP) and Medicaid

If you or your dependent(s) are otherwise eligible to enroll in NYSHIP and you lose Eligibility under CHIP or Medicaid or you become eligible for premium assistance from the State under its CHIP or Medicaid program, you have special rights to enroll in NYSHIP. If you request enrollment for yourself and/or your dependent(s) within 60 days after the loss of eligibility under CHIP or Medicaid or the date you are determined to be eligible for premium assistance, you are not subject to a waiting period and your NYSHIP coverage may begin on the effective date of that event.

Substitute the following for the sixth and eighth bullets under "Changes permitted only after certain events" in the "Costs, Pre-Tax Program and What Your Paycheck Stub Shows" section on page 14 of your NYSHIP General Information Book.

PTCP Changes

- Your spouse/domestic partner has a change in employment status which results in either acquiring or losing eligibility for health insurance coverage.
- There is a significant change in your or your spouse's/domestic partner's health coverage which is attributable to your spouse's/domestic partner's employment.

Substitute the following for the first sentence of "Other money-saving programs" in the "Costs, Pre-Tax Program and What Your Paycheck Stub Shows" section on page 29 of your NYSHIP General Information Book.

Money Saving Programs

Ask your agency Health Benefits Administrator about the **Productivity Enhancement Program (PEP)**, a benefit that may allow you to exchange annual and personal leave for a reduction in your health insurance premium.

Substitute the following for the first sentence of "1. Complete the minimum service period" under "Eligibility for retiree coverage" in the "Continuing Coverage When You Retire" section on page 19 of your NYSHIP General Information Book.

Retiree Eligibility

First, you must have completed a minimum service period which is determined by the date on which you last entered State service and you must have served a minimum of one year with the employer from whose service you retired.

Add the following to the end of the "COBRA: Continuation of Coverage" section on page 29 of your NYSHIP General Information Book.

New York State: Extended continuation of coverage

Effective July 1, 2009. If you lose COBRA coverage because you have reached the end of your 18 or 29 month continuation period, you are eligible for a supplemental continuation of coverage from the State of New York. This extended coverage will continue until the earlier of 36 months (combined length of COBRA and New York State continuation coverage) or until you no longer qualify for COBRA coverage (other than 18 or 29 month limits) as stated in the "When you no longer qualify for COBRA coverage" section under "COBRA: Continuation of Coverage" on page 29 of your NYSHIP General Information Book.

The enrollee will pay the full premium cost plus a 2 percent administrative fee for this coverage continuation.

EMPIRE BLUECROSS BLUESHIELD CERTIFICATE OF INSURANCE

Hospital and Related Expenses Program

Substitute the following for the second paragraph of item 2. B. "The annual coinsurance maximum" in the "Network and non-network benefits" on page 50 of your Empire BlueCross BlueShield Certificate as amended in your September 2005 Empire Plan Amendments.

Copayments

Effective January 1, 2010. The **annual coinsurance maximum** for covered inpatient/outpatient services received at a non-network hospital and covered inpatient services received at a non-network skilled nursing facility or hospice care facility is \$1,500 for the enrollee, \$1,500 for the enrolled spouse/domestic partner, and \$1,500 for all dependent children combined. After the maximum levels have been reached, inpatient services are paid in full. Hospital emergency room visits are subject to a \$60 copayment, outpatient surgical expenses are subject to a \$40 copayment, diagnostic outpatient services (diagnostic radiology, including mammography; diagnostic laboratory tests and administration of Desferal for Cooley's Anemia) are subject to a \$30 copayment and physical therapy services are subject to a \$15 copayment. Once you have paid \$500 in non-network coinsurance, up to an additional \$500 of covered services is reimbursable under the Basic Medical Program.

Substitute the following for "Copayment for emergency care" in the "Outpatient Hospital Care" section on page 52 of your Empire BlueCross BlueShield Certificate as amended in your September 2005 Empire Plan Amendments.

Copayment for emergency care

Effective January 1, 2010. You must pay the first \$60 in charges (copayment) for emergency care in a hospital emergency room. See page 51, "Outpatient Hospital Care" for emergency care. Hospitals may require payment of this charge at the time of service.

The \$60 emergency room copayment covers use of the facility for **emergency care** and services of the emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and pathology services. Refer to your UnitedHealthcare Certificate, page 79, "What is Covered Under the Basic Medical Program (non-participating providers)", if you receive bills for hospital emergency room service from these providers.

You will not have to pay this \$60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for the first three paragraphs of "Copayment for outpatient hospital services" in the "Outpatient Hospital Care" section on pages 52-53 of your Empire BlueCross BlueShield Certificate as amended in your September 2005 Empire Plan Report.

Copayments for outpatient hospital services

Effective January 1, 2010. You must pay the first \$40 (copayment) for outpatient surgical expenses and the first \$30 (copayment) for one or more of the diagnostic outpatient services, listed below, for each visit to a network facility or the greater of 10 percent of charges or \$75 at a non-network facility. Hospitals may require payment of this charge at the time of service.

Hospital outpatient services include:

- Diagnostic radiology, including mammography according to above guidelines
- Diagnostic laboratory tests
- Administration of Desferal for treatment of Cooley's Anemia

One copayment (\$40 if surgery is included or \$30 if it is not) covers the outpatient facility and will apply for all covered hospital outpatient services. You will not have to pay the copayments for outpatient surgical expenses or hospital outpatient expenses if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you at that time as an inpatient.

Add the following as the last paragraph of “Coordination of Benefits (COB)” on page 61 of your Empire BlueCross BlueShield Certificate.

Coordination of Benefits

When The Empire Plan is secondary to another insurance plan

If a provider receives prior approval to provide services from the primary carrier, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the primary carrier has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the certificate language.

Substitute the following for the first paragraph of “Benefits after termination” in the “Termination of Your Empire BlueCross BlueShield Coverage” section on page 63 of your Empire BlueCross and BlueShield Certificate.

Benefits after termination

3. **Benefits after termination.** If Empire BlueCross BlueShield determines that you are totally disabled from an illness, injury or pregnancy on the date of termination of your coverage, Empire BlueCross BlueShield hospitalization and related expense benefits are available while you are totally disabled from that illness, injury or pregnancy for expenses incurred within a period of 90 days after the termination of your coverage, or during a hospital stay that began within that 90 day period.

Substitute the following for “Recovery of overpayments” in the “Miscellaneous Provisions” section on page 64 of your Empire BlueCross BlueShield Certificate as amended in your September 2005 General Information Book and Empire Plan Certificate Amendments.

Recovery of overpayments and subrogation

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident or due to medical malpractice, and we pay benefits as a result of that injury or illness, we may subrogated to and may succeed to all rights of recovery against the party responsible for your illness or injury to the reasonable value of any benefits we have paid to the extent permitted by law. This right is limited to the amount of any settlement that represents medical expenses that have been paid. This means we may have the right, as a plaintiff-intervener in an action you may commence, to proceed against the party responsible for your injury or illness to recover the benefits we have paid. However, we shall not exercise our right to bring an independent action if you do not pursue a claim.

UNITEDHEALTHCARE CERTIFICATE OF INSURANCE

Medical/Surgical Program

Substitute the following for “AD. Scheduled Pharmaceutical Amount” under “Meaning of Terms Used” on page 75 of your UnitedHealthcare Certificate as amended in your January 2009 Empire Plan Report.

Meaning of Terms Used

AD. **Scheduled Pharmaceutical Amount** means:

For covered Pharmaceutical Products, the lowest of:

- a. the actual charge billed for such covered Pharmaceutical Product or
- b. the average wholesale price of such Pharmaceutical Product as set forth in the Red Book published by Thompson Reuters. The Pharmaceutical Product pricing information is updated annually on October 1st. When

Red Book does not have a price for the product, UnitedHealthcare uses alternative pricing sources such as RJ Health or an internally developed pharmaceutical pricing resource to determine the average wholesale price for the covered Pharmaceutical Product. UnitedHealthcare will provide specific pricing information to you upon request.

You are responsible for any amount billed by a non-participating provider which exceeds the Scheduled Pharmaceutical Amount in addition to the annual deductible and coinsurance amounts.

Substitute the following for the first sentence of “1. Annual Deductible” in the “Basic Medical Program” section on page 79 of your UnitedHealthcare Certificate.

Annual Deductible

Effective January 1, 2010. For calendar year 2010, the Basic Medical annual deductible for medical services performed and supplies prescribed by non-participating providers is \$250 for the enrollee, \$250 for the enrolled spouse/domestic partner, and \$250 for all dependent children combined.

Substitute the following for the last bullet of “...prior authorization for Qualified Procedures” under “Infertility Benefits” on page 88 of your UnitedHealthcare Certificate.

Infertility Benefits

- Sperm, egg and/or inseminated egg procurement, processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of sperm or embryos).

Add the following as the last paragraph of “Coordination of Benefits (COB)” on page 93 of your UnitedHealthcare Certificate.

Coordination of Benefits

When The Empire Plan is secondary to another insurance plan

If a provider receives prior approval to provide services from the primary carrier, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the primary carrier has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the certificate language.

Substitute the following for item 1. and the first paragraph of item 2 of “How” and items 1. and 2. of “When” under “How, When and Where to Submit Claims” on pages 94-95 of your UnitedHealthcare Certificate.

How

- A. If you go to a participating provider, MPN Network provider, HCAP-approved provider or a Basic Medical Provider Discount Program provider, all you have to do is ensure that the provider has accurate and up-to-date personal information – name, address, health insurance identification number and signature – needed to complete the claim form. The provider fills out the form and sends it directly to UnitedHealthcare. The claim forms are in each provider’s office.
- B. If you use a non-participating provider or a provider that is not in the MPN Network or is not HCAP-approved, claims may be submitted at any time after the appropriate annual deductible has been satisfied but not later than 90 days (120 days – for claims incurred in Calendar Year 2010 or later) after the end of the Calendar Year in which covered medical expenses were incurred or 90 days (120 days – for claims incurred in Calendar Year 2010 or later) after Medicare or another plan processes your claim. However, you may submit claims later if it was not reasonably possible for you to meet this deadline (for example, due to your illness); you must provide documentation.

When

- A. If you use a participating provider, MPN Network provider, HCAP-approved provider or a Basic Medical Provider Discount Program provider, your provider will submit a claim to UnitedHealthcare.
- B. If you use a non-participating provider or a provider that is not in the MPN Network or is not HCAP-approved, claims may be submitted at

any time after the appropriate annual deductible has been satisfied but not later than 90 days (120 days – for claims incurred in Calendar Year 2010 or later) after the end of the calendar year in which covered medical expenses were incurred or 90 days (120 days – for claims incurred in Calendar Year 2010 or later) after Medicare or another plan processes your claim. However, you may submit claims later if it was not reasonably possible for you to meet this deadline (for example, due to your illness); you must provide documentation.

Substitute the following for “Recovery of overpayments” in the “Miscellaneous Provisions” section on page 98 of your UnitedHealthcare Certificate as amended in your September 2005 General Information Book and Empire Plan Certificate Amendments.

**Recovery of
overpayments
and
subrogation**

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident or due to medical malpractice, and we pay benefits as a result of that injury or illness, we may be subrogated to and may succeed to all rights of recovery against the party responsible for your illness or injury to the reasonable value of any benefits we have paid to the extent permitted by law. This right is limited to the amount of any settlement that represents medical expenses that have been paid. This means we may have the right, as a plaintiff-intervener in an action you may commence, to proceed against the party responsible for your injury or illness to recover the benefits we have paid. However, we shall not exercise our right to bring an independent action if you do not pursue a claim.

EMPIRE PLAN MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

Substitute the following for the Group Health Incorporated Certificate of Insurance on pages 102-136 of your Empire Plan Certificate as amended in your January 1, 2007 Amendments contained in your January 2008 Empire Plan Report.

Certificate of Insurance UnitedHealthcare Insurance Company of New York (Herein referred to as UHIC-NY) Hauppauge, New York

UHIC-NY certifies that under and subject to the terms and conditions of Group Policy 715116 issued to

State of New York (Herein called the State)

each eligible Enrollee shall become insured on the Enrollee's own account and on account of each of the Enrollee's eligible Dependents for the coverage described in this Certificate, on the later of:

- A. January 1, 2010, or
- B. the date determined in accordance with the Regulations of the President of the Civil Service Commission.

The benefits under this Program do not at any time provide paid-up insurance, or loan or cash values.

No agent has the authority:

- A. to accept or to waive any required notice or proof of a claim; nor
- B. to extend the time within which any such notice or proof must be given to UHIC-NY.

This Certificate may not be assigned by the Enrollee. An Enrollee's benefits may not be assigned prior to a loss.

The insurance evidenced by this Certificate does NOT provide basic hospital insurance, basic medical insurance or major medical insurance as defined by the New York State Insurance Department.

UnitedHealthcare Insurance Company of New York
Form No. 0110MHSA
UnitedHealthcare Insurance Company of New York
Certificate of Insurance

Section IV

UHIC-NY CERTIFICATE OF INSURANCE

Mental Health and Substance Abuse Program

Overview

The Empire Plan Mental Health and Substance Abuse Program provides comprehensive coverage for mental health and substance abuse care, including alcoholism. UHIC-NY is the Program insurer and OptumHealth is the administrator of the Program.

Review the benefits and exclusions in this Certificate before you obtain services. Excluded services and conditions will not be covered under the Program. If your inpatient or outpatient treatment is found not medically necessary, you will not receive any Empire Plan benefits, and you will be responsible for the full cost of care.

Coverage

Covered services for mental health and substance abuse care, including care for alcoholism, include:

- Emergency assessments at all times;
- Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge;
- Alternatives to inpatient care (such as certified residential treatment facilities and certified halfway houses, etc.);
- Outpatient mental health services;
- Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment;
- Substance abuse structured outpatient rehabilitation and aftercare;
- Electro-convulsive therapy;
- Medication management;
- Ambulance services; and
- Psychiatric second opinions.

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth



Before you seek non-emergency mental health or substance abuse care, including treatment for alcoholism, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. You should call within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

If you do not call, or if you call but do not follow OptumHealth's recommendations, you may receive a lower level of benefits for non-emergency services.

Calling OptumHealth is the first step in ensuring that you will be eligible to receive the highest level of benefits. OptumHealth is always open, 24 hours a day, every day of the year.

The Empire Plan Mental Health and Substance Abuse Program has two levels of benefits for covered services: network coverage and non-network coverage.

Highest level of benefits when you call and follow OptumHealth's recommendations

You qualify for network coverage when:

- You call OptumHealth before your treatment begins, and
- You are treated by a provider OptumHealth recommends.

Usually, you will be referred to a network provider or facility. However, you will still qualify for network coverage if OptumHealth refers you to a non-network provider or facility.

Lower benefits when you don't call OptumHealth, you don't use a recommended provider

Benefits are available for medically necessary care when you don't call OptumHealth and use a recommended provider. These benefits are lower than those available when you call OptumHealth and seek care from a recommended provider.

You will receive non-network coverage for covered services when:

- You do not call OptumHealth, and/or
- You call OptumHealth but do not follow their recommendations.

The mental health and substance abuse care you obtain will be covered by UHIC-NY only if it meets the conditions for coverage stated in this Certificate. Read this entire Certificate in order to understand the Program.

Program benefits and responsibilities apply to you and your enrolled dependents whenever you seek Empire Plan coverage for these services, even if you have Medicare or other health insurance coverage, as well.

Key terms are used throughout the Certificate. Read the section of the Certificate called "Meaning of Key Terms" for definitions of these terms.

If you have questions about The Empire Plan Mental Health and Substance Abuse Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-855-2881.

Meaning of Key Terms

Here are definitions of the key terms used throughout this Certificate. In order to understand them fully, read the entire Certificate to see how these terms are used in the context of the coverage provided to you.

- A. **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by OptumHealth.
- Under network coverage, residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by OptumHealth.
- B. **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.
- C. **Certification or Certified** means a determination by OptumHealth that mental health care or substance abuse care or proposed care is a medically necessary, covered service in accordance with the terms of this Certificate.
- D. **Clinical Referral Line** means the clinical resource and referral service which you must call prior to receiving any covered services. You may call 24 hours a day, every day of the year. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.
- E. **Coinsurance** means, for Approved Facility services, the difference between the billed charge and the percentage covered; and, for Practitioner services, the difference between the reasonable and customary charge and the percentage covered. Coinsurance applies to non-network covered services.

- F. **Concurrent Review** means OptumHealth’s utilization review and medical management program under which OptumHealth reviews the medical necessity of mental health care and substance abuse services. OptumHealth’s review is conducted by a team of licensed psychiatric nurses, social workers, board-certified or board-eligible psychiatrists and clinical psychologists, to determine whether proposed services are medically necessary for your diagnosed condition(s). This program includes combined outpatient and inpatient review as described in this Certificate.
- G. **Copayment** means the amount you are required to pay for covered services you obtain from a network provider for outpatient services under the Mental Health and Substance Abuse Program. Please refer to the “Schedule of Benefits for Covered Services” for the exact amount of copayment. Copayment applies only to network covered services and non-network emergency room covered services.
- H. **Course of Treatment** means the period of time, as determined by OptumHealth, required to provide mental health and substance abuse care to you for the resolution or stabilization of specific symptoms or a particular disorder. A course of treatment may involve multiple providers.
- I. **Covered Expenses** means:
1. For care under the network portion of the Program, the network allowance for any medically necessary covered services provided to you under the Program by a network provider.
 2. For non-network Practitioner care, the Reasonable and Customary charge for medically necessary covered services provided to you under the Program. No more than the Reasonable and Customary charge less coinsurance will be considered by the Program for medically necessary covered services.
 3. For care in a non-network Approved Facility, the billed amount for medically necessary covered services provided to you under the Program. No more than the billed amount less coinsurance will be considered by the Program for medically necessary covered services.
- A covered expense is incurred on the date you receive the service.
- J. **Covered Services** means medically necessary mental health and substance abuse care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.
- K. **Crisis Intervention Visits** means visits for treatment of an acute emotional disturbance which results in a temporary inability to function in one’s daily life.
- Examples of situations meeting this definition include:
1. An acute psychotic reaction,
 2. Loss of coping capacity, and
 3. Any situation endangering the patient, others or property.
- Such crisis is usually precipitated by an adverse event such as:
1. Loss of crucial person through death, divorce or separation,
 2. Serious illness, accident or sudden heart attack,
 3. Onset of disabling psychiatric symptoms, or
 4. A social trauma such as rape or robbery.
- L. **Deductible** means the amount you must pay each calendar year for covered services under the non-network portion of the Mental Health and Substance Abuse Program before payment will be made to you. Deductibles apply only to the non-network coverage. The Substance Abuse outpatient deductible, and the Mental Health outpatient deductible for Practitioner services are separate deductibles and cannot be combined.

The amount applied toward satisfaction of the deductible will be the lower of the following:

1. The amount you actually paid for a medically necessary service or supply covered under the non-network portion of the Program; or
2. For Practitioner services, the reasonable and customary charge less coinsurance for such service; or
3. For Approved Facility services, the billed amount less coinsurance for such service.

The Mental Health and Substance Abuse Program deductibles are separate from the Basic Medical and Managed Physical Medicine Program annual deductibles. The mental health and substance abuse deductibles cannot be combined with any other deductible or out-of-pocket provision.

- M. **Emergency Care** is care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
1. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy;
 2. Serious impairment to such person's bodily functions;
 3. Serious dysfunction of any bodily organ or part of such person; or
 4. Serious disfigurement of such person.
- N. **Inpatient Services** means those services rendered in an approved facility to a patient who has been admitted for an overnight stay and is charged for room and board.
- O. **Medically Necessary** means a service which OptumHealth has certified to be:
1. Medically required;
 2. Having a strong likelihood of improving your condition; and
 3. Provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by OptumHealth.

Although a practitioner may recommend that a covered person receive a service or be confined to an approved facility, that recommendation does not mean:

1. That such service or confinement will be deemed to be medically necessary; or
2. That benefits will be paid under this Program for such service or confinement.

- P. **Mental Health Care** means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of OptumHealth, is directed predominately at treatable behavioral manifestations of a condition that OptumHealth determines:
1. Is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
 2. Substantially or materially impairs a person's ability to function in one or more major life activities; and
 3. Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- Q. **Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you under the network provider portion of the Program.

- R. **Network Coverage** means the level of benefits provided by the Program when you receive medically necessary services from a provider recommended to you by OptumHealth.
- S. **Network Facility** means an approved facility that has entered into a network provider agreement as an independent contractor with OptumHealth. The records of OptumHealth shall be conclusive as to whether an institution has a network provider agreement in effect on the date that you obtain services. A non-network facility can be considered a network facility on a case-by-case basis when approved by OptumHealth.
- T. **Network Practitioner** means a practitioner who has entered into an agreement with OptumHealth as an independent contractor to provide covered services to you. The records of OptumHealth shall be conclusive as to whether a person had a network provider agreement in effect on the date that you obtained services. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by OptumHealth.
- U. **Network Provider** means either a network practitioner or a network facility.
- V. **Non-network Coverage** means the level of reimbursement paid by the Program when you receive medically necessary covered services from a non-network provider and you comply with the Program requirements outlined in this Certificate.
- W. **Non-network Facility** means an approved facility that has not entered into an agreement with OptumHealth to provide covered services to you.
- X. **Non-network Provider** means a practitioner or approved facility that has not entered into an agreement with OptumHealth to provide covered services to you.
- Y. **OptumHealth Behavioral Solutions** (also referred to as OptumHealth) is the company selected by the State of New York to administer The Empire Plan Mental Health and Substance Abuse Program. OptumHealth provides services for UnitedHealthcare Insurance Company of New York in the administration of this Program.
- Z. **Outpatient Services** means those services rendered in a practitioner's office or in the department of an approved facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.
- AA. **Partial Hospitalization** (day or night care center) means a visit in a center maintained by an approved facility that has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program.
- AB. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who maintains an active clinical practice and who renders medical necessity decisions.
- AC. **Practitioner** means:
1. A psychiatrist; or
 2. A psychologist; or
 3. A licensed and registered social worker with at least six years of post-degree experience who is qualified by the New York State Board for Social Work. In New York State, this is determined by the "R" number given to qualified social workers. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or
 4. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist; or

5. A Registered Nurse Practitioner: a nurse with a Master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided; must be certified and have a practice agreement in effect with a network physician; or
6. A professional corporation; or
7. A university faculty corporation.

AD. **Program** means The Empire Plan Mental Health and Substance Abuse Program.

AE. **Provider** means a practitioner or approved facility that supplies you with covered services under the Mental Health and Substance Abuse Program. The fact that a practitioner or approved facility claims to supply you with mental health or substance abuse services has no bearing on whether that practitioner or approved facility is a provider covered under the Program. A service or supply which can lawfully be provided only by a licensed practitioner or approved facility will be covered by this Program only if such practitioner or approved facility is in fact properly licensed and is permitted, under the terms of that license, to do so at the time you receive a covered service or supply. A person or facility that is not properly licensed cannot be a covered provider under the Program. The records of any agency authorized to license persons or facilities who supply covered services shall be conclusive as to whether that person or facility was properly licensed at the time you receive any service or supply.

AF. **Reasonable and Customary** means the lowest of:

1. The actual charge for services; or
2. The usual charge for services by the Practitioner; or
3. The usual charge for services of other Practitioners in the same or similar geographic area for the same or similar service.

AG. **Referral** means the process by which OptumHealth's 24-hour, toll-free Clinical Referral Line refers you to a provider to obtain covered mental health and substance abuse care.

AH. **Structured Outpatient Rehabilitation Program** means a program that provides substance abuse care and is an operational component of an approved facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an approved facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents.

The program must also meet all applicable federal, state and local laws and regulations.

A Structured Outpatient Rehabilitation Program is a program in which the patient participates, on an outpatient basis, in prescribed formalized treatment, which includes an intensive phase involving more than once-weekly treatment, as well as an aftercare component, which includes weekly follow-up/support visits. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

AI. **Substance Abuse Care** means medically necessary care provided by an eligible provider for the illness or condition that OptumHealth has determined:

1. Is a clinically significant behavioral or psychological syndrome or pattern;
2. Substantially or materially impairs a person's ability to function in one or more major life activities; and

3. Is a condition which has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this Program.
- AJ. **UHC-NY** means UnitedHealthcare Insurance Company of New York, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.
- AK. **You/Your** means any Empire Plan enrollee covered by this Program and any dependent member of an enrollee's family who is also covered. Enrollee and dependent are defined in your NYSHIP General Information Book. Where this Certificate refers to "you" making the call to obtain network coverage, "you"/"your" can also mean a member of your family or household.

How to Receive Benefits for Mental Health and Substance Abuse Care

You must call

Before you seek treatment for mental health or substance abuse, including alcoholism, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth, even if another plan is your primary coverage.

You must call OptumHealth even when a doctor refers you to a mental health professional or facility. You may ask OptumHealth to refer you to a particular provider. However, OptumHealth will determine the appropriateness of this referral.

The advantages of making this call are:

- You will receive help in choosing the right provider. You don't have to guess which professional can help you.
- You will have access to an extensive network of quality providers in your area, carefully chosen for their training and experience.
- You may reduce out-of-pocket expenses and you can get the recommended care without worrying about the bill. Except for any copayments, the bill is paid when you follow OptumHealth's recommendation, and there are no claim forms.
- When you use OptumHealth for intervention following a significant life crisis, such as a death, trauma, divorce, illness or work and life issues, you are eligible for up to three outpatient visits without a copayment.
- You will receive confidential help - no one needs to know you are making the call.

The OptumHealth network and the referral process

The Mental Health and Substance Abuse Program has two levels of benefits: network coverage and non-network coverage. By following the Program requirements for network coverage, you will receive the highest level of benefits. Please refer to the "Schedule of Benefits for Covered Services" for a complete description of the two benefit levels.

OptumHealth's network gives you access to a wide range of providers when you need mental health or substance abuse care. These providers are in your community and many of them have been caring for Empire Plan enrollees and their families for years.

Program requirements apply nationwide, even if another plan is your primary coverage

You must follow the requirements for the Mental Health and Substance Abuse Program whenever you will be seeking Empire Plan coverage for these services. Program requirements apply nationwide regardless of where you seek mental health and substance abuse services.

Program requirements for network coverage

In order to receive network coverage, the highest level of benefits:

- You must call OptumHealth before outpatient treatment begins;
- You must call OptumHealth before you are admitted as an inpatient. (Requirements are different for an emergency. See “Emergency Services”);
and
- You must be treated by a provider or admitted to a facility recommended to you by OptumHealth.

When you follow these requirements for network coverage, the network provider will be responsible for obtaining certification from OptumHealth. Both you and your provider will receive written confirmation from OptumHealth indicating the care (number of visits or length of stay) that has been certified.

Lower benefits apply if you don't call OptumHealth or if you don't use a recommended provider

Benefits are available for medically necessary care when you do not follow the Program requirements for network coverage. These benefits are lower than those available when you call OptumHealth and seek care from a recommended provider. See the “Schedule of Benefits for Covered Services” for a description of non-network coverage.

Before you choose a non-network provider, consider the high cost of treatment.

Program requirements if you choose to use a non-network provider

For a non-emergency inpatient admission to a non-network facility, you must call OptumHealth before the admission to have the medical necessity of the admission certified.

If you choose a non-network provider for outpatient treatment, call OptumHealth early in your treatment so that OptumHealth can begin the process of determining whether your treatment will be covered. You must call before the sixth visit to begin the certification process. OptumHealth must certify any outpatient visits beyond the tenth such visit during any course of treatment.

When you use a non-network provider, you are responsible for obtaining certification from OptumHealth. You will receive written confirmation from OptumHealth indicating the care (number of visits or length of stay) which has been certified.

Emergency services

In an emergency situation, you should go or be taken to the nearest hospital emergency room for treatment. If you are admitted to a facility for emergency care, you should call OptumHealth within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization for certification.

You must pay the first \$60 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this \$60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

When you receive medically necessary covered services from a non-network provider in a certified emergency, the Program will provide network coverage until you can be transferred to a network facility.

Call OptumHealth

You or a member of your family or household may place the call to The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. In the case of an emergency or urgent situation, your doctor, a member of your doctor's staff, or the hospital admitting office, may place the call for you. Where this Certificate refers to “you” making the call, keep in mind that other people listed may also call. **But it is your responsibility to see that the call is made.**

Clinical Referral Line

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth for referrals to providers. Whenever you or your family faces a mental health or substance abuse problem, including alcoholism, getting help begins with a call to OptumHealth. By making the call before you receive services, and then obtaining care from a provider referred to you by OptumHealth, you will qualify for network coverage. Usually, OptumHealth will refer you to a network practitioner or network facility. However, you will also qualify for network coverage if no network provider is available and OptumHealth refers you to a non-network provider. The Clinical Referral Line is available 24 hours a day, every day of the year. It is staffed by clinicians who have professional experience in the mental health and substance abuse field. These highly trained and experienced clinicians are available to help you determine the most appropriate course of action.

Call when you use a non-network provider

To be certain that your care is medically necessary when you choose to use a non-network provider, you must call OptumHealth to start the certification process. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth between 8 am and 5 pm Eastern time on business days and select the Customer Service Line. Ask OptumHealth to mail an Outpatient Treatment Report to your non-network provider. If you do not call when you use a non-network provider, and your inpatient or outpatient treatment is not found to be medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

Show your identification card

You must show your identification card every time you request covered services from network providers. Possession and use of an identification card is not entitlement to benefits. Coverage for benefits is subject to verification of eligibility for the date covered services are rendered, and all the terms, conditions, limitations and exclusions set out in this Certificate.

Release of medical records

As a condition of receiving benefits under this Program, you authorize any provider who has provided services to you to provide OptumHealth and UHIC-NY with all information and records relating to such services. At all times, OptumHealth and UHIC-NY will treat medical records and information in strictest confidence.

Concurrent Review

OptumHealth reviews treatment

After the initial certification, OptumHealth monitors your care throughout your course of treatment to make sure it remains consistent with your medical needs. The Concurrent Review is based on the following criteria and applies whether you choose a network or non-network provider:

- Medical necessity of treatment to date,
- Diagnosis,
- Severity of illness,
- Proposed level of care, and
- Alternative treatment approaches.

OptumHealth must continue to certify the medical necessity of your care for your Empire Plan benefits to continue.

If OptumHealth determines that inpatient treatment is no longer necessary, OptumHealth will notify you, your doctor and the facility no later than the day before the day on which inpatient benefits cease. OptumHealth will assist you in making the transition from inpatient care to the appropriate level of treatment with a network provider.

Certification denial and appeal process: deadlines apply

Only an OptumHealth peer advisor can deny certification. If certification for any covered service is denied, OptumHealth will notify you and the applicable provider of the denial and provide information on how to request an appeal of such decision by telephone. You will have 60 days to request an appeal.

When you or your provider requests an appeal involving a clinical matter, another OptumHealth peer advisor will review your case and make a determination. The determination will be made as soon as your provider provides all pertinent information to the OptumHealth peer advisor in a telephone review. You and your provider will be advised in writing of OptumHealth's decision.

If the peer advisor's determination is to continue to deny certification, you and your provider will be provided with written information on how to request a second level appeal of OptumHealth's decision. You have 30 days from the date of your receipt of OptumHealth's written denial notice to request a second level appeal.

Level 2 Clinical appeals are conducted by a panel of two board-certified psychiatrists from OptumHealth and a Clinical Manager. Panel members have not been involved in the previous determinations of the case. A determination will be made within 10 business days of the date OptumHealth received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision. See "Appeals: 60-day deadline" for additional information. Administrative appeals are reviewed by OptumHealth, in consultation with UHIC-NY as needed.

What is Covered Under the Mental Health and Substance Abuse Program

This section describes Program coverage for inpatient and outpatient care.

Inpatient care

Coverage for inpatient care includes the following medically necessary services:

- A. **Hospital Services** for the treatment of mental health and substance abuse are covered.
- B. **Residential Treatment Facilities, Halfway Houses and Group Homes.** Covered charges will be payable in full under the network coverage if the admission is certified by OptumHealth. Confinements for these services are covered only under the network portion of the Program. **No benefits are available under non-network coverage.**
- C. Mental health care in a **partial hospitalization** program (day or night care center), maintained by an approved facility, on its premises, is covered.
- D. **Psychiatric Treatment or Consultation While You Are a Mental Health, Substance Abuse or Medical Inpatient in an Approved Facility.** If you are receiving inpatient mental health/substance abuse treatment from a practitioner who bills separately from the hospital or approved facility, you are covered for medically necessary visits.
If you are admitted to a hospital for a medical condition and the admission interrupts your certified outpatient mental health and substance abuse care, you may continue to receive certified care from your practitioner during your inpatient stay.
- E. **Inpatient Psychiatric Consultations on a Medical Unit.** You are covered for medically necessary inpatient mental health visits by a practitioner while you are on the medical unit of a hospital.

Outpatient care

Coverage for outpatient care includes the following medically necessary services:

- A. **Emergency Care** at a hospital for treatment of mental health/substance abuse, where you are not admitted as an inpatient following that care, is considered an outpatient service.

- B. **Office Visits.** You are covered for office visits for general mental health care.
- C. **Psychiatric Second Opinion.** You are covered for second opinions by a practitioner of equal or higher credentials. Example: Only another psychologist or a psychiatrist may give a second opinion on a psychologist's diagnosis.
- D. **Family Sessions.** For each patient's alcoholism, alcohol abuse, or substance abuse treatment program, benefits are allowed for covered family sessions. When the covered alcoholic, alcohol abuser or substance abuser is participating in a Structured Outpatient Substance Abuse Rehabilitation Program, up to 20 family sessions (per calendar year) for family members covered under the same Empire Plan enrollment are included in the program. If the alcoholic, alcohol abuser, or substance abuser is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are eligible for up to 20 family sessions (per calendar year), subject to OptumHealth certification.
- E. **Substance Abuse-Structured Outpatient Rehabilitation Program.** Covered benefits are allowed for Substance Abuse Structured Outpatient Rehabilitation Programs.
- F. **Psychological Testing and Evaluations.** These services are covered if OptumHealth authorizes them and determines that they are medically necessary for the condition(s) indicated. If these services are provided on an outpatient basis, the network provider **must** obtain OptumHealth certification of this care before testing begins. If testing is being provided by a non-network provider, you **must** have your practitioner call OptumHealth and obtain certification of the care before testing begins. There are no network or non-network benefits available if testing is not certified by OptumHealth in advance.
- G. **Ambulance Services for Mental Health and Substance Abuse Care.** You are covered for medically necessary hospital-based ambulance services, commercial ambulance services or organized voluntary ambulance services for transfers from non-network facilities to network facilities approved in advance by OptumHealth. You are also covered for emergency transport to an approved facility.
You are not covered under this Program for ambulance service to a facility in which you do not receive mental health and substance abuse care.
- H. **Crisis Intervention Visits.** Crisis intervention visits are covered under the network coverage and will be payable in full up to the network allowance for up to three visits in a given crisis. OptumHealth reviews documentation of each crisis for approval.
A statement of necessity satisfactory to OptumHealth must be submitted by the network provider in order for a period of treatment to be considered a crisis. **Paid-in-full benefits for these services are available under network coverage only.**
- I. **Electro-Convulsive Therapy.** Electro-Convulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All Electro-Convulsive therapy must be certified by OptumHealth before the service is received.
- J. **Medication Management.** You are covered for office visits to a psychiatrist specializing in psychopharmacology for the ongoing review and monitoring of psychiatric medications.
- K. **Home-Based Counseling.** You are covered for home-based care provided by a Network Practitioner. **Benefits for these services are available under network coverage only.**

- L. **Registered Nurse Practitioner.** Services provided by a Registered Nurse Practitioner under the direct supervision of a network physician are covered under the Plan when medically necessary. Services include prescribing medication refills and other services performed within the scope of the Registered Nurse Practitioner's license in the state where the services are performed. **Benefits for these services are available under network coverage only.**
- M. **Telephone Counseling.** Telephone counseling provided by a network practitioner is covered. **Benefits for these services are available under network coverage only.**

Schedule of Benefits for Covered Services

OPTUMHEALTH MUST CERTIFY ALL COVERED SERVICES AS MEDICALLY NECESSARY. IF OPTUMHEALTH DOES NOT CERTIFY YOUR INPATIENT OR OUTPATIENT TREATMENT AS MEDICALLY NECESSARY, YOU WILL NOT RECEIVE ANY EMPIRE PLAN BENEFITS AND YOU WILL BE RESPONSIBLE FOR THE FULL COST OF CARE.

NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

If you follow the requirements for network coverage, you are responsible for paying only the following copayments:

- A. No copayments are required for inpatient care.
- B. You pay the first \$15 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.
- C. You pay the first \$15 charged for any other outpatient visit including Home-Based and Telephone Counseling in place of an office visit, except no copayment is required for:
 - Crisis Intervention, up to three visits per crisis
 - Electro-Convulsive Therapy - facility and therapist charges, if certified by OptumHealth
 - Psychiatric Second Opinion, if requested and certified by OptumHealth
 - Ambulance Service
 - Mental Health Psychiatric Evaluations, if requested and certified by OptumHealth
 - Prescription drugs, if billed by an approved facility
 - Home-based counseling when provided in place of inpatient care
- D. You pay the first \$60 charged for emergency care in a hospital emergency room. You will not have to pay this \$60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

The network provider from whom you receive covered services is responsible for collecting the copayment from you.

Note - Copayments do **NOT** count toward meeting your non-network coverage deductibles, Basic Medical deductible or Basic Medical Coinsurance Maximum. Copayments count toward meeting your non-network outpatient practitioner coinsurance maximum.

Except for the copayment that the network provider obtains directly from you, a network provider does not bill you directly for services or supplies you obtain as a network benefit. Your payment to the network provider is limited to the copayment. The network provider requests payment directly from UHIC-NY.

NON-NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

YOU ARE RESPONSIBLE FOR OBTAINING OPTUMHEALTH CERTIFICATION FOR CARE OBTAINED FROM A NON-NETWORK PROVIDER

If you do **NOT** follow the requirements for network coverage, UHIC-NY pays the following covered percentages:

A. For Practitioner Services: 80 percent of reasonable and customary charges for covered services after you meet the annual deductible for outpatient practitioner services. There are two separate deductibles for this program – one for mental health services and one for substance abuse care. Each deductible is \$250 per enrollee, \$250 per covered spouse/domestic partner and \$250 for all covered dependents combined. The covered percentage becomes 100 percent of the reasonable and customary charge for covered services once the coinsurance maximum is met.

There are two separate coinsurance maximums for this program – one for mental health services and one for substance abuse care. Each coinsurance maximum is \$500 for the enrollee, \$500 for the enrolled spouse/dependent partner and \$500 for all dependent children combined.

The \$500 coinsurance maximum expense for the enrollee, the spouse/domestic partner and all children combined will be reduced to \$300 in calendar year 2010 for employees in or equal to a salary grade 6 or below as of January 1, 2010.

B. For Approved Facility Services: 90 percent of billed charges for covered services. There are two separate coinsurance maximums for this program—one for mental health services and one for substance abuse care. Each coinsurance maximum is \$1,500 for you, the enrollee, \$1,500 for your enrolled spouse/domestic partner and \$1,500 for all enrolled dependent children combined. Each coinsurance maximum is applied as follows:

1. You are responsible for the first \$500 of coinsurance, then
2. You may apply for reimbursement of the next \$500 of coinsurance, upon written request of the enrollee, then
3. You are responsible for the final \$500 of coinsurance.

OptumHealth will consider non-network coverage for covered expenses after you meet your annual deductible. You are responsible for the coinsurance amount up to the coinsurance maximum. And, for practitioner services, any charges in excess of the reasonable and customary charge.

Note - The amount you pay for inpatient and outpatient services does **NOT** count toward meeting your Basic Medical deductible or Basic Medical coinsurance maximum under the Medical/Surgical Program or toward the non-network coinsurance maximum under the Hospital Program. No deductible, coinsurance or maximum coinsurance amount may be counted toward satisfying any other deductible, coinsurance or maximum coinsurance amount.

Maximums

Mental Health and Substance Abuse coverage is unlimited (no maximum) for outpatient and inpatient services, except that outpatient treatment sessions for family members of an alcoholic, alcohol abuser, or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

Exclusions and Limitations

Covered services do not include and no benefits will be provided for the following:

- A. Expenses incurred prior to your effective date of coverage or after termination of coverage, except under conditions described in the “Miscellaneous Provisions” section.
- B. Services or supplies which are not Medically Necessary as defined in the section “Meaning of Key Terms”.
- C. Treatment which is not Mental Health Care or Substance Abuse Care as defined in the section “Meaning of Key Terms”.
- D. Services or supplies which are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.
- E. Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non disorder conditions which may be a focus of clinical attention (V codes); except for family visits for substance abuse or alcoholism.
- F. Services deemed Experimental or Investigational are not covered under this Plan. However, OptumHealth and UHIC-NY may deem an Experimental or Investigational Service is covered under this Plan for treating a life-threatening sickness or condition if they determine that the Experimental or Investigational Service at the time of the determination:
 - Is proved to be safe with promising efficacy; and
 - Is provided in a clinically controlled research setting; and
 - Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- G. Custodial care, except when medically necessary. Custodial care means the spectrum of services and supplies provided expressly for protection and monitoring in a controlled environment, regardless of setting, and assistance to support essentials of daily living in patients whose persistent symptoms, behavior management, and/or medical and psychological problems result in serious ongoing impairment in central life role function. Such care includes, but is not limited to, state hospital care which is custodial for children who are wards of the state or for enrollees or eligible dependents who are incarcerated in a state hospital facility.
- H. Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered.
- I. Private duty nursing.
- J. Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient treatment reports and statements of medical necessity.
- K. Charges for services, supplies or treatments that are covered charges under any other portion of The Empire Plan, including but not limited to detoxification of newborns and medically complicated detoxification cases.
- L. Services, treatment or supplies provided as a result of any Workers’ Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.

- M. Services or supplies you receive for which no charge would have been made in the absence of coverage under the Mental Health and Substance Abuse Program, including services from an Employee Assistance Program.
- N. Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.
- O. Any charges for professional services performed by a person who ordinarily resides in your household or who is related to you, such as a spouse, parent, child, brother or sister or by an individual or institution not defined by OptumHealth as a provider.
- P. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you, to the extent that medical expenses are identified in the judgment or settlement.
- Q. Conditions resulting from an act of war (declared or undeclared) or an insurrection which occurs after December 5, 1957.
- R. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Abuse Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

Coordination of Benefits

If you are covered by an additional group health insurance program (such as a program provided by your spouse's employer) which contains coverage for mental health or substance abuse, The Empire Plan will coordinate benefit payments with the other program. One program pays its full benefit as the primary insurer and the other program pays secondary benefits.

Coordination of benefits helps ensure that you receive all the benefits to which you are entitled from each plan, while preventing duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge.

The Empire Plan does not coordinate benefits with any health insurance policy which you or your dependent carries on a direct-pay basis with a private carrier.

The procedures followed when Empire Plan benefits are coordinated with those provided under another program are detailed below. Each of The Empire Plan carriers follows these procedures.

- A. "Coordination of Benefits" means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for a service covered under both group plans.
- B. Definitions
 - 1. "Plan" means a plan which provides benefits or services for or by reason of mental health or substance abuse care and which is:
 - a. A group insurance plan; or
 - b. A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
 - c. A self-insured or non-insured plan; or

- d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
 - e. A group service plan; or
 - f. A group prepayment plan; or
 - g. Any other plan which covers people as a group; or
 - h. A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan; or
 - i. A mandatory “no fault” automobile insurance plan.
2. “Order of Benefit Determination” means the procedure used to decide which plan will determine its benefits before any other plan. Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan which reserves the right to take the benefits or services of other plans into account to determine its benefits, will be treated separately from those parts which do not.
- C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for the service you receive.
- D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has coordination of benefits or similar provision with the same order of benefit determination as stated in Item E. Empire Plan benefits are to be determined, in that order, before the benefits under the other plan.
- E. When more than one plan covers the person making the claim, the order of benefit payments is determined using the first of the following rules which applies:
- 1. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
 - 2. When this plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are not divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph 3 below.)
 - a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
 - b. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
 - c. If the other plan does not have the rule described in subparagraphs a. and b. above, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
 - d. The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.
 - 3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child;

- b. Then, the plan of the spouse of the parent with custody of the child;
 - c. Then, the plan of the parent not having custody of the child; and
 - d. Finally, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such actual knowledge.
4. The benefits of a plan which cover a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule 4. is ignored.
 5. If none of the rules in 1. through 4. above determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.
- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
 - G. Any information about covered expenses and benefits which is needed to apply this provision may be given or received without consent of or notice to any person, subject to the provisions in Article 25 of the General Business Law.
 - H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, The Empire Plan carriers have the right to recover the overpayment. You will be required to return any overpayment to the appropriate Empire Plan carrier; or at UHIC-NY's discretion, future benefits may be offset by this amount. In most cases, this will be the amount that was paid by the other plan.
 - I. If payments which should have been made under The Empire Plan have been made under other plans, the party that paid will have the right to recover the appropriate amount from The Empire Plan carriers.
 - J. There is a further condition which applies under the network provider program. When either Medicare or a plan other than The Empire Plan pays first, and if for any reason the total sum reimbursed by the other plan and The Empire Plan is less than the network provider billed the other plan, the network provider may not charge the balance to you.

When The Empire Plan is secondary to another insurance plan

If a provider receives prior approval to provide services from the primary carrier, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the primary carrier has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the certificate language.

Impact of Medicare on this Plan

Even if Medicare or another plan provides your primary coverage, you must follow OptumHealth's requirements whenever you will be seeking Empire Plan coverage for mental health or substance abuse services.

Definitions

- A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.

- B. **Primary Payor** means the plan that will determine the medical benefits which will be payable to you first.
- C. **Secondary Payor** means a plan that will determine your medical benefits after the primary payor.
- D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.
- E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in the General Information section of this book.
- F. You will be considered **disabled** if you are eligible for Medicare due to your disability.
- G. You will be considered to have **end-stage renal disease** if you have permanent kidney failure.

Coverage

When you are eligible for primary coverage under Medicare, the benefits under this Plan may change.

*Please refer to the General Information section of this book for information on when you must enroll for Medicare and when Medicare becomes your primary coverage. **If you or your dependent is eligible for primary Medicare coverage - even if you or your dependent fails to enroll - your covered medical expenses will be reduced by the amount available under Medicare, and UHIC-NY will consider the balance for payment, subject to copayment, deductible and coinsurance.***

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained in the last paragraph of this section, “Medicare Advantage Plans and your Empire Plan coverage” below.

- A. **Retired Employees and/or their Dependents** – If you or your dependents are eligible for primary coverage under Medicare - even if you or they fail to enroll - your covered medical expenses will be reduced by the amount that would have been paid by Medicare, and UHIC-NY will consider the balance for payment, subject to copayment, deductible and coinsurance.

If the provider has agreed to accept Medicare assignment, covered expenses will be based on the provider’s reasonable charge or the amount approved by Medicare, whichever is less. If the provider has not agreed to accept Medicare assignment, covered expenses will be based on Medicare’s limiting charge, as established under federal, or in some cases, state regulations.

No benefits will be paid for services or supplies provided by a skilled nursing facility.

- B. **Active State Employees and/or their Dependents** – This Plan will automatically be the primary payor for active employees, regardless of age, and for the employee’s enrolled dependents (except for a domestic partner eligible for Medicare due to age) unless end-stage renal disease provisions apply; Medicare, the secondary payor. As the primary payor, UHIC-NY will pay benefits for covered medical expenses under this Plan; as secondary payor, Medicare’s benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

Note to domestic partners: Under Social Security law, Medicare is primary for an active employee’s domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

- C. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must be enrolled in Parts A and B of Medicare when first eligible and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.
- D. **End-Stage Renal Disease.** For those eligible for Medicare due to end-stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first 30 months of treatment, then Medicare becomes primary. See “Medicare end-stage renal disease coordination” in the General Information section. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.
- E. **Veterans’ Facilities.** Where services are provided in a U.S. Department of Veterans’ Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a non-governmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan’s benefits. The Medicare amount payable is the amount that would be payable to a Medicare-eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a non-governmental facility.
- F. ***If you or your dependents are eligible and enrolled for primary coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.***

Medicare Advantage Plans and your Empire Plan coverage

If you or your dependent enrolls in a Medicare Advantage plan, in addition to your Empire Plan coverage, The Empire Plan will not provide benefits for any services available through your Medicare Advantage plan or services that would have been covered by your Medicare Advantage plan if you had complied with the plan’s requirements for coverage. Covered medical expenses under The Empire Plan are limited to expenses not covered under your Medicare Advantage plan. If your Medicare Advantage plan has a Point-of-Service option that provides partial coverage for services you receive outside the plan, covered medical expenses under The Empire Plan are limited to the difference between the Medicare Advantage plan’s payment and the amount of covered expenses under The Empire Plan.

Claims

OptumHealth as administrator for UHIC-NY is responsible for processing claims at the level of benefits determined by OptumHealth and for performing all other administrative functions under The Empire Plan Mental Health and Substance Abuse Program.

Claim payment for covered services

Claim payments for covered services you receive under this Program will be made only as follows:

- A. **Network Coverage:** When you receive network coverage, UHIC-NY will make any payment due under this Program directly to the provider, except for the copayment amount which you pay to the provider.

- B. **Non-Network Coverage:** When you receive non-network coverage, any payment due under the Program will be made **ONLY** to you. You are responsible for payment of charges at the time they are billed to you. You must file a claim with OptumHealth for services rendered under non-network coverage in order to receive reimbursement. UHIC-NY pays you the non-network covered amount for the covered service you obtained. You are always required to pay the deductible, coinsurance amounts and the amount billed to you in excess of the non-network covered amount. Also, you are ultimately responsible for paying your provider any amount not paid by UHIC-NY. However, UHIC-NY may pay the non-network covered amount directly to an approved facility in lieu of paying you.
- C. **Assignment Prohibited:** Your right under this Program to receive reimbursement for outpatient covered services when such services are provided under non-network coverage, except inpatient services and partial hospitalization where agreed to by UHIC-NY, may not be assigned or otherwise transferred to any other person or entity including, without limitation, any such provider. Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, UHIC-NY or OptumHealth.

How, When and Where to Submit Claims

How

If you use non-network coverage, you must submit a claim. You may obtain a claim form from:

OptumHealth Behavioral Solutions
P.O. Box 5190
Kingston, NY 12402-5190

or

You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

When

If you are enrolled in Medicare, an “Explanation of Medicare Benefits” form **must be submitted with the completed claim form or detailed bills** to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the “Explanation of Medicare Benefits” form and other documents for your records.

Remember - If you are enrolled with Medicare as the primary payor, bills must be submitted to Medicare first.

- A. If you use network coverage, your provider will submit a claim to OptumHealth.
- B. If you use non-network coverage, you must meet the Mental Health and Substance Abuse Program annual deductibles before the claims are paid. These deductibles are separate from the other Empire Plan annual deductibles.

Claims must be submitted to either OptumHealth or Medicare, if applicable, within 90 days (120 days-for claims incurred in Calendar Year 2010 or later) after the end of the calendar year in which covered expenses were incurred. If the claim is first sent to Medicare, it must be submitted to OptumHealth within 90 days (120 days-for claims incurred in Calendar Year 2010 or later) after Medicare processes the claim.

Benefits will not be paid for claims submitted after the 90 days regardless of whether you or a provider submits the claim unless meeting this deadline has not been reasonably possible (for example, due to your illness).

Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an “Explanation of Medicare Benefits” form to: OptumHealth Behavioral Solutions, P.O. Box 5190, Kingston, NY 12402-5190.

Fraud

Any person who intentionally defrauds an insurance company by filing a claim which contains false or misleading information, or conceals information which is necessary to properly examine a claim has committed a crime.

Verification of claims information

OptumHealth and UHIC-NY have the right to request from approved facilities, practitioners or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

Questions

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

COBRA: Continuation of Coverage

Your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you and your covered dependents, are explained in your NYSHIP General Information Book.

Miscellaneous Provisions

Confined on effective date of coverage

If you become covered under this Plan and on that date are confined in a hospital or similar facility for care or treatment or are confined at home under the care of a doctor for an illness or injury, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

Benefits after termination of coverage

If you are Totally Disabled due to a mental health or substance abuse condition on the date coverage ends on your account, UHIC-NY will pay benefits for covered expenses for that Total Disability, on the same basis as if coverage had continued without change, until the day you are no longer Totally Disabled or 90 days after the day your coverage ended, whichever is earlier.

“Total Disability” and “Totally Disabled” mean that because of a mental health/substance abuse condition you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

Confined on date of change of options

“Option” means your choice under the New York State Health Insurance Program of either The Empire Plan, which includes the Mental Health and Substance Abuse Program, or a Health Maintenance Organization (HMO). See your NYSHIP General Information Book for information on option transfer.

If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or similar facility for mental health/substance abuse care or confined at home under the care of a practitioner for mental health/substance abuse care:

- A. If the transfer is out of The Empire Plan, and you are confined on the day coverage ends, benefits will end on the effective date of option transfer; and
- B. If the transfer is into The Empire Plan, benefits under the Mental Health and Substance Abuse Program are payable for covered expenses to the extent they exceed or are not paid through your former HMO.

Termination of coverage

- A. Coverage will end when you are no longer eligible to participate in The Empire Plan. Refer to your NYSHIP General Information Book.
- B. If this Program ends, your coverage will end.
- C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your NYSHIP General Information Book.
- D. If a payment which is required by the State of New York for coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim which is incurred before your coverage ends will not be affected.

Refund to UHIC-NY for overpayment of benefits

If UHIC-NY pays benefits under this Program for covered expenses incurred on your account, and it is found that UHIC-NY paid more benefits than should have been paid because all or some of those expenses were not paid by you, or you were also paid for all or some of those expenses by another source, UHIC-NY will have the right to a refund from you.

The amount of the refund is the difference between the amount of benefits paid by UHIC-NY for those expenses and the amount of benefits which should have been paid by UHIC-NY for those expenses.

If benefits were paid by UHIC-NY for expenses not covered by this Program, UHIC-NY will have the right to a refund from you.

Time limit for starting lawsuits

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive notice that benefits have been denied.

Appeals

Appeals: 60-day deadline

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 60 days after you receive a notice of denial of the certification or claim to:

OptumHealth Behavioral Solutions
Attn: BH Appeals Dept.
900 Watervliet Shaker Road, Suite 103
Albany, NY 12205-1002

When requesting a review, please state the reason you believe the certification or claim was improperly denied and submit any data, questions or comments you deem appropriate.

Please refer to “Certification denial and appeal process: deadlines apply” for information about the appeals process.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, One Commerce Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9am - 5pm Eastern time.

Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if UHIC-NY has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, including treatment of a rare disease, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary

If you have been denied coverage on the basis that the service is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

- A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and
- B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedures was presented for consideration, UHIC-NY must have upheld the denial; **or** you and UHIC-NY must agree in writing to waive any internal appeal.

Your right to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

- A. The service must otherwise be a Covered Service under the Policy; and
- B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedures was presented for consideration, UHIC-NY must have upheld the denial; **or** you and UHIC-NY must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A. A service, procedure or treatment that two 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 New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable) or, in the case of a rare disease, a health service or procedure that is likely to benefit you in the treatment of a rare disease; or
- B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the 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 life-threatening or disabling condition or disease.

The External Appeal process

If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that

the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and UHIC-NY have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. UHIC-NY will provide an external appeal application with the final adverse determination issued through UHIC-NY's internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which UHIC-NY based its denial, the External Appeal Agent will share this information with UHIC-NY in order for it to exercise its right to reconsider its decision. If UHIC-NY chooses to exercise this right, UHIC-NY will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), UHIC-NY does not have a right to reconsider its 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 UHIC-NY. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two 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, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and UHIC-NY 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 UHIC-NY's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, UHIC-NY will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, UHIC-NY will only cover the costs of services required to provide treatment to you according to the design of the trial. UHIC-NY shall 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 the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and UHIC-NY. The External Appeal Agent's decision is admissible in any court proceeding.

The insurer will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. UHIC-NY will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an External Appeal

It is **YOUR RESPONSIBILITY** to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

45-day deadline

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from UHIC-NY that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. UHIC-NY has no authority to grant an extension of this deadline.

EMPIRE PLAN PRESCRIPTION DRUG PROGRAM

Substitute “Medco Pharmacy” for “Medco by Mail” wherever it appears in your UnitedHealthcare Insurance Company of New York Certificate in the “General Information Book and Empire Plan Certificate Amendments” dated January 2009.

Substitute the following for the list of drugs requiring prior authorization under “Prior authorization required for certain drugs” in the “Your Benefits and Responsibilities” section on page 255 of your UnitedHealthcare Insurance Company of New York Certificate in the “General Information Book and Empire Plan Certificate Amendments” dated January 2009.

Prior Authorization

The following is a list of drugs (including generic equivalents) that require prior authorization:

- | | | | |
|------------------|--------------------|--------------|---------------------|
| • Adcirca | • Forteo | • Letairis | • Sporanox |
| • Amevive | • Growth Hormones | • Myobloc | • Stelara |
| • Aranesp | • Humira | • Nuvigil | • Synagis |
| • Avonex | • Immune Globulins | • Orencia | • Tracleer |
| • Betaseron | • Increlex | • Pegasys | • Tysabri |
| • Botox | • Infergen | • Peg-Intron | • Tyvaso |
| • Cimzia | • Intron-A | • Provigil | • Ventavis |
| • Copaxone | • Iplex | • Rebif | • Weight Loss Drugs |
| • Dysport | • Kineret | • Remicade | • Xolair |
| • Enbrel | • Kuvan | • Remodulin | • Xyrem |
| • Epogen/Procrit | • Lamisil | • Revatio | |
| • Extavia | | • Roferon-A | |
| • Flolan | | • Simponi | |

Substitute the following for “Deadline for filing claims” under “Non-Network Pharmacies” in the “How to Use Your Empire Plan Prescription Drug Program” section on page 258 of your UnitedHealthcare Insurance Company of New York Certificate in the “General Information Book and Empire Plan Certificate Amendments” dated January 2009.

Deadline for filing claims

Claims must be submitted within 90 days (120 days – for claims incurred in Calendar Year 2010 or later) after the end of the calendar year in which the prescription drugs were purchased, or 90 days (120 days – for claims incurred in Calendar Year 2010 or later) after another plan processes your claim, whichever is later, unless it was not reasonably possible for you to meet this deadline (for example, due to your illness).

Substitute the following for the first paragraph of “Benefits after termination of coverage” in the “Miscellaneous Provisions” sections on page 263 of your UnitedHealthcare Certificate as amended in your January 2009 General Information Book and Empire Plan Certificate Amendments.

Benefits after termination

You may be Totally Disabled on the date coverage ends on your account. If so, benefits will be provided on the same basis as if coverage had continued with no change until the day you are no longer Totally Disabled or for 90 days after the date your coverage ended, whichever is earlier.

January 1, 2010 Empire Plan Copayments for Employees of New York State represented by CSEA

Services by Empire Plan Participating Providers

You pay only your copayment when you choose Empire Plan Participating Providers for covered services. Check your directory for Participating Providers in your geographic area, or ask your provider. For Empire Plan Participating Providers in other areas and to check a provider's current status, call UnitedHealthcare at 1-877-7-NYSHIP (1-877-769-7447) toll free or use the Participating Provider Directory on the internet at <https://www.cs.state.ny.us>.

Office Visit	\$15
Office Surgery	\$15
(If there are both an Office Visit charge and an Office Surgery charge by a Participating Provider in a single visit, only one copayment will apply, in addition to any copayment due for Radiology/Laboratory Tests.)	
Radiology, Single or Series; Diagnostic Laboratory Tests	\$15
(If Outpatient Radiology and Outpatient Diagnostic Laboratory Tests are charged by a Participating Provider during a single visit, only one copayment will apply, in addition to any copayment due for Office Visit/Office Surgery.)	
Mammography, according to guidelines	\$15
Adult Immunizations	\$15
Allergen Immunotherapy	No copayment
Well-Child Office Visit, including Routine Pediatric Immunizations	No copayment
Prenatal Visits and Six-Week Check-Up after Delivery	No copayment
Chemotherapy, Radiation Therapy, Dialysis	No copayment
Authorized care at Infertility Center of Excellence	No copayment
Hospital-based Cardiac Rehabilitation Center	No copayment
Anesthesiology, Radiology, Pathology in connection with inpatient or outpatient network hospital services	No copayment
Free-standing Cardiac Rehabilitation Center visit	\$15
Urgent Care Center	\$15
Contraceptive Drugs and Devices when dispensed in a doctor's office	\$15
(in addition to any copayment(s) due for Office Visit/Office Surgery and Radiology/Laboratory Tests)	
Outpatient Surgical Locations (including Anesthesiology and same-day pre-operative testing done at the center)	\$30
Medically appropriate professional ambulance transportation	\$35

Chiropractic Treatment or Physical Therapy Services by Managed Physical Network (MPN) Providers

You pay only your copayment when you choose MPN network providers for covered services. To find an MPN network provider, ask the provider directly, or call UnitedHealthcare at 1-877-7-NYSHIP (1-877-769-7447) toll free. Internet: <https://www.cs.state.ny.us>.

Office Visit	\$15
Radiology; Diagnostic Laboratory Tests	\$15

(If Radiology and Laboratory Tests are charged by an MPN network provider during a single visit, **only one** copayment will apply, in addition to any copayment due for Office Visit.)

Hospital Outpatient Department Services

Emergency Care	\$60*
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(The \$60 hospital outpatient copayment covers use of the facility for **Emergency Room Care**, including services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.)

Network Hospital Outpatient Department Services

Surgery	\$40*
Diagnostic Laboratory Tests	\$30*
Diagnostic Radiology (including mammography, according to guidelines)	\$30*
Administration of Desferal for Cooley's Anemia	\$30*
Physical Therapy (following related surgery or hospitalization)	\$15
Chemotherapy, Radiation Therapy, Dialysis	No copayment
Pre-Admission Testing/Pre-Surgical Testing prior to inpatient admission	No copayment

***Only one** copayment (\$40 copayment if surgery is included; \$30 copayment if diagnostic outpatient services only) per visit will apply for all covered hospital outpatient services rendered during that visit. The copayment covers the outpatient facility. Provider services may be billed separately. You will not have to pay the facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you, at that time, as an inpatient.

Be sure to follow **Benefits Management Program** requirements for hospital admissions, skilled nursing facility admission and Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine tests.

**Mental Health and Substance Abuse Services
by Network Providers When You Are Referred
by UnitedHealthcare**

Call UnitedHealthcare at 1-877-7-NYSHIP
(1-877-769-7447) toll free before beginning treatment.

Visit to Outpatient Substance Abuse Treatment Program	\$15
Visit to Mental Health Professional	\$15
Psychiatric Second Opinion when Pre-Certified	No copayment
Mental Health Crisis Intervention (three visits)	No copayment
Inpatient	No copayment

Empire Plan Prescription Drugs

(Only one copayment applies for up to a
90-day supply.)

**Up to a 30-day supply from a participating
retail pharmacy or through the Mail Service
Pharmacy**

Generic Drug.....	\$5
Preferred Brand-Name Drug	\$15
Non-Preferred Brand-Name Drug.....	\$40**

**31- to 90-day supply from a participating
retail pharmacy**

Generic Drug.....	\$10
Preferred Brand-Name Drug	\$30
Non-Preferred Brand-Name Drug	\$70**

**31- to 90-day supply through the Mail Service
Pharmacy**

Generic Drug.....	\$5
Preferred Brand-Name Drug	\$20
Non-Preferred Brand-Name Drug.....	\$65**

**If you choose to purchase a brand-name drug that
has a generic equivalent, you pay the non-preferred
brand-name copayment *plus* the difference in cost
between the brand-name drug and its generic
equivalent (with some exceptions), not to exceed
the full cost of the drug.

The Empire Plan Carriers and Programs

To reach any of The Empire Plan carriers, call toll free **1-877-7-NYSHIP (1-877-769-7447)**.

The one number is your first step to Empire Plan information. Check the list below to know which carrier to select. When you call 1-877-7-NYSHIP, listen carefully to your choices and press or say your selection at any time during the message. Follow the instructions and you'll automatically be connected to the appropriate carrier.

The Empire Plan Hospital Benefits Program *Empire BlueCross BlueShield, New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407. Web site: www.empireblue.com. Call for information regarding hospital and related services.*



Benefits Management Program for Pre-Admission Certification You must call Empire BlueCross BlueShield before a maternity or scheduled hospital admission, within 48 hours after an emergency or urgent hospital admission and before admission or transfer to a skilled nursing facility (includes rehabilitation facilities).



Centers of Excellence for Transplants Program You must call Empire BlueCross BlueShield before a hospital admission for the following transplant surgeries: bone marrow, peripheral stem cell, cord blood stem cell, heart, liver, lung and heart/lung, kidney and pancreas/kidney. Call for information about Centers of Excellence.

The Empire Plan Medical/Surgical Benefits Program *UnitedHealthcare Insurance Company of New York, P.O. Box 1600, Kingston, NY 12402-1600. Web site: www.myuhc.com. Call for information on benefits under Participating Provider, Basic Medical Provider Discount and Basic Medical Programs, predetermination of benefits, claims and participating providers.*

Managed Physical Medicine Program/MPN Call UnitedHealthcare for information on benefits and to find MPN network providers for chiropractic treatment and physical therapy. If you do not use MPN network providers, you will receive a significantly lower level of benefits.



Benefits Management Program for Prospective Procedure Review of MRI, MRA, CT, PET scans and Nuclear Medicine tests You must call UnitedHealthcare before having an elective (scheduled) procedure or nuclear medicine test.



Home Care Advocacy Program (HCAP) You must call UnitedHealthcare to arrange for paid-in-full home care services, enteral formulas, diabetic shoes and/or durable medical equipment/supplies. If you do not follow HCAP requirements, you will receive a significantly lower level of benefits. You must also call UnitedHealthcare for HCAP approval of an external mastectomy prosthesis costing \$1,000 or more.



Infertility Benefits You must call UnitedHealthcare for prior authorization for the following Qualified Procedures, regardless of provider: Assisted Reproductive Technology (ART) procedures including in vitro fertilization and embryo placement, Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Intracytoplasmic Sperm Injection (ICSI) for the treatment of male infertility, assisted hatching and microsurgical sperm aspiration and extraction procedures; sperm, egg and/or inseminated egg procurement and processing and banking of sperm and inseminated eggs. Call UnitedHealthcare for information about infertility benefits and Centers of Excellence.



Centers of Excellence for Cancer Program You must call UnitedHealthcare to participate in The Empire Plan Centers of Excellence for Cancer Program.

The Empire Plan Mental Health and Substance Abuse Program *OptumHealth (administrator for UnitedHealthcare), Mailing Addresses: Claims/General Correspondence - OptumHealth Behavioral Solutions, P.O. Box 5190, Kingston, NY 12402-5190; Appeals - OptumHealth Behavioral Solutions, Attn: BH Appeals Dept., 900 Watervliet Shaker Road, Suite 103, Albany, NY 12205-1002. You must call OptumHealth before beginning any non-emergency treatment for mental health or substance abuse, including alcoholism. You will receive the highest level of benefits by calling and following OptumHealth's recommendations. In a life-threatening situation, go to the emergency room. Call within 48 hours or as soon as reasonably possible after inpatient admission.*



The Empire Plan Prescription Drug Program *UnitedHealthcare appeals, grievances, prior authorization documentation, general correspondence: Empire Plan Prescription Drug Program, P.O. Box 5900, Kingston, NY 12402-5900. Claim forms from retail pharmacies: Empire Plan Prescription Drug Program, P.O. Box 14711, Lexington, KY 40512. Mail Service Pharmacy: Medco, P.O. Box 6500, Cincinnati, OH 45201-6500. For the most current list of prior authorization drugs, call The Empire Plan or go to <https://www.cs.state.ny.us>.*

The Empire Plan NurseLineSM Call for health information and support, 24 hours a day, seven days a week. To listen to the Health Information Library, enter PIN number 335 and a four-digit topic code from The Empire Plan NurseLine brochure.

Teletypewriter (TTY) numbers for callers when using a TTY device because of a hearing or speech disability:
Empire BlueCross BlueShieldTTY only: **1-800-241-6894**
UnitedHealthcareTTY only: **1-888-697-9054**
OptumHealthTTY only: **1-800-855-2881**
The Empire Plan Prescription Drug ProgramTTY only: **1-800-759-1089**