NYSHIP
New York State Health Insurance Program

General Information Book & Empire Plan Certificate Amendments

For Contract Affected Employees
of the State of New York
in the New York State Correctional Officers
and Police Benevolent Association **(NYSCOPBA)**
and for their enrolled Dependents,
COBRA enrollees with their benefits
and Young Adult Option Enrollees

April 1, 2010

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

Keep these amendments with your June 1, 2002 *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 June 1, 2002 *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)

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.

Your Spouse

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.

Add the following as the first three bullets of the first paragraph under "3. Your child age 19 or over who is a full-time student" and delete the following paragraphs: the fourth paragraph under "3. Your child age 19 or over who is a full-time student" and the paragraphs entitled "Spring student, enrolled for fall", "Spring student, enrolled for fall, but does not attend in fall", "Spring student, not enrolled for fall", "Spring student, seeking fall admission" and "Withdrawing from school" under "3. Your child age 19 or over who is a full-time student" in the "Who is Eligible" section on pages 5 and 6 of the General Information Book.

Leaving school before graduation

- The end of the third month following the month in which the dependent completes a semester.
- The end of the month in which attendance at school ends if the semester is not completed and proof of the last day of attendance for the semester is provided or the end of the third month following the month that the last semester was completed, whichever is later.
- The starting date of the semester if the semester is not completed and no proof of attendance is provided or the end of the third month following the month that the last semester was completed, whichever is later.

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 pages 5 and 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.

Substitute the following for the second paragraph under "When your Family coverage begins" in the "Coverage: Individual or Family" section on page 9 of your NYSHIP General Information Book as amended in the September 2005 Amendments.

When your Family coverage begins

If you and a spouse or domestic partner each have individual coverage in NYSHIP and you change to one Family coverage, there is no waiting period.

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 "Another money-saving program" in the "Costs, Pre-Tax Program and What Your Paycheck Stub Shows" section on page 14 of your NYSHIP General Information Book.

Health Care Spending Account

Also ask for information on the **Health Care Spending Account**, a flex spending benefit that allows you to set aside pre-tax dollars to pay for medically necessary health-related expenses that are not reimbursed by your health insurance or any other benefit plan. For more information and annual enrollment deadlines you can go to www.flexspend.state.ny.us.

Substitute the following for the first sentence of "Health insurance coverage while you are on Workers' Compensation" under "How Changes in Your Status Affect Coverage" on page 18 of your NYSHIP General Information Book.

Workers' Compensation

If you are enrolled in NYSHIP and are removed from the payroll because of an accepted work-related injury or occupational condition, you can continue your health insurance coverage at the employee's share of the premium for up to 12 months per injury. Effective April 1, 2010, if you are receiving Workers' Compensation payments due to an assault injury that occurred during the course of employment, you can continue your health insurance coverage at the employee's share of the premium for up to 24 months per injury.

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 30 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 30 of your *NYSHIP General Information Book*.

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

Substitute the following for "Medicare premium reimbursement" and "Reimbursement for dependents not automatic" in the "Medicare: When You Must Enroll and Coordinating with NYSHIP" section on pages 35 and 36 of your NYSHIP General Information Book.

Medicare Reimbursement

Medicare premium reimbursement

If you or your dependent is Medicare primary, the State will reimburse you for the usual (base) cost of "original" Medicare Part B monthly premiums unless you are receiving reimbursement from another source.

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is a federal law that requires some people to pay a higher premium for their Medicare Part B coverage based on their income. If you are required to pay an income-related monthly adjustment amount in addition to the standard Medicare Part B premium, you are eligible to be reimbursed for this additional premium by NYSHIP.

Retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions, COBRA enrollees and covered spouses/domestic partners who

become Medicare primary at age 65 are automatically reimbursed for Medicare Part B premium. Enrollees and covered dependents who become Medicare primary before age 65 because of disability or end-stage renal disease must apply for reimbursement. You must take a photocopy of your dependent's Medicare identification card to your agency Health Benefits Administrator. Be sure to include your name and identification number on the photocopy. If you are not an active employee, contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344.

To claim the additional IRMAA reimbursement, eligible enrollees are required to apply for and document the amount paid in excess of the standard Medicare Part B premium.

For information on how to apply, a list of documents required or questions on IRMAA, you may call the Employee Benefits Division at 457-5754 (if you are located in the 518 area code) or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

THE EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM

Substitute the following for "You must call the Benefits Management Program at 1-800-638-9918:" on page 43 of The Empire Plan Benefits Management Program.

Benefits Management

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for Prospective Procedure Review:

Before having an elective (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA); Computerized Tomography (CT), Positron Emission Tomography (PET) scan or nuclear medicine test unless you are having the test as an inpatient in a hospital. *(See "Prospective Procedure Review: MRI" on page 46 for details.)*

Substitute the following for "4. Prospective Procedure Review: MRI" under "The Empire Plan Benefits Management Program: Benefits and Your Responsibilities" on page 46 of The Empire Plan Benefits Management Program.

Prospective Procedure Review

4. **Prospective Procedure Review**
   To protect your Empire Plan benefits, you must call The Empire Plan if you or one of your enrolled dependents is scheduled for an elective (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine test unless you are having the test as an inpatient in a hospital.

   Call as soon as your doctor suggests one of the above procedures. Call at least two weeks before the scheduled test. If you did not receive at least two weeks notice from your doctor, call The Empire Plan Benefits Management Program immediately. The nurse will make every effort to complete the review prior to your scheduled test. If you do not receive written confirmation from The Empire Plan, call your Benefits Management Program nurse **before** you go ahead with the procedure.

Substitute the following for "MRI" wherever it appears in the "Benefits Management Program", "Empire BlueCross BlueShield" and "UnitedHealthcare" Certificates.

Benefits Management Program

Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) or Nuclear Medicine test.

Copayment

Effective April 1, 2010. *Substitute "$20 copayment" for "$18 copayment" wherever the $18 appears in your Empire BlueCross BlueShield Certificate.*

Substitute the following for the heading and first sentence of "Outpatient MRI" in the "Benefits Management Program" section on pages 51 and 52 of your Empire BlueCross BlueShield Certificate.

Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests

Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests

- If you did not follow the Prospective Procedure Review requirements for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scans or Nuclear Medicine tests and the procedure was performed in the outpatient department of a hospital, Empire BlueCross BlueShield will conduct a medical necessity review.

Substitute the following for the second paragraph of item 2. B. "The annual coinsurance maximum" in the "Network and non-network benefits" on page 52 of your Empire BlueCross BlueShield Certificate as amended in your July 2006 Empire Plan Report.

Copayments

Effective April 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, hospital outpatient services are subject to a $35 copayment and physical therapy services are subject to a $20 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 the first paragraph and "1. Conditions for skilled nursing facility care." under "Skilled Nursing Facility Care" on page 55 of your Empire BlueCross BlueShield Certificate.

Skilled Nursing Facility Care

If Medicare is your primary coverage, The Empire Plan does not provide Skilled Nursing Facility benefits even for short-term rehabilitative care. If The Empire Plan is your primary coverage, benefits are subject to the requirements of The Empire Plan Benefits Management Program.

1. Conditions for skilled nursing facility care. Empire BlueCross BlueShield will pay for your care in a skilled nursing facility described in Item 2 below when you meet the following conditions:

   A. Care in a skilled nursing facility must be medically necessary. Care is medically necessary when it must be furnished by skilled personnel to assure your safety and achieve the medically desired result.

   Custodial care, which is care that is primarily assistance with the activities of daily living, is not covered.

   The Benefits Management Program requirement to call for pre-admission certification applies to skilled nursing facility admissions including transfers from a hospital.

   B. Coverage will only be provided for as long as inpatient hospital care would have been required if care in a skilled nursing facility were not provided. If your care is pre-certified, you, your doctor and the facility will be notified no later than the day before your certification for skilled nursing facility care will cease.

   C. Benefits in a skilled nursing facility are not provided by Empire BlueCross BlueShield if you are eligible to receive primary benefits

from Medicare, even if you fail to enroll in Medicare. You are not eligible to receive Empire BlueCross BlueShield benefits if your Medicare benefits for skilled nursing facilities have been exhausted.

Refer to the General Information section of this book for information on primary coverage under Medicare.

Substitute the following for the second paragraph of "What is covered?" under "Centers of Excellence for Transplants Program" on page 57 of your Empire BlueCross BlueShield Certificate as amended in the January 2007 Empire Plan Report.

Transplants Program

When the above services are pre-authorized by Empire BlueCross BlueShield and provided at a Center of Excellence for Transplants facility, you will not have to make any copayments and a travel, lodgings and meal expenses benefit is available to you. The travel and meals benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: meals, auto mileage (personal or rental car), economy class airfare, train fare, taxi fare, parking, tolls and shuttle or bus fare from lodging to the Center of Excellence.

Add the following as the last paragraph of "Coordination of Benefits (COB)" on page 63 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 65 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 66 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.

Copayment

Effective April 1, 2010. *Substitute "$20 copayment" for "$18 copayment" wherever the $18 appears in the UnitedHealthcare Certificate.*

Substitute the following for the second paragraph under the heading "Basic Medical Program (A Non-Participating Provider)" under "Plan Overview" on page 72 of your UnitedHealthcare Certificate.

Plan Overview

You submit claims to UnitedHealthcare. For covered services and supplies, The Empire Plan reimburses you 80 percent of the reasonable and customary charges for covered services and supplies or the Scheduled Pharmaceutical Amount for Pharmaceutical Products or the actual billed charges, whichever is less.

Substitute the following for "Outpatient MRI" in the "Plan Overview" section on page 73 of your UnitedHealthcare Certificate.

Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests

Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests

If you have Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scans or Nuclear Medicine tests, that require **Prospective Procedure Review (PPR),** you must comply with PPR requirements. If you do not comply, you may be subject to paying a higher share of the cost as explained in the *"Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review"* section on page 84. If you do not comply with PPR requirements and UnitedHealthcare's review does not confirm that the procedure was medically necessary, you will be responsible for the full charges. *Read the "Benefits Management Program" section for complete information.*

Substitute the following for the first two lines of item N. "Medically Necessary or Medical Necessity" in the "Meaning of Terms Used" section on page 75 of your UnitedHealthcare Certificate.

Meaning of Terms Used

N. **Medically Necessary or Medical Necessity** means the health care services, supplies and Pharmaceutical Products which are determined by UnitedHealthcare to be medically appropriate and:

Substitute the following for item O. "Covered Medical Expenses" in the "Meaning of Terms Used" section on pages 75 and 76 of your UnitedHealthcare Certificate.

O. **Covered Medical Expenses** under the Basic Medical portion of this Plan means the reasonable and customary charges for covered medical services performed or supplies prescribed by a doctor or the Scheduled Pharmaceutical Amount for Pharmaceutical Products provided by a doctor, except as otherwise provided below, due to your sickness, injury or pregnancy. A covered medical expense is incurred on the date the service, supply, or Pharmaceutical Product is received by you. In order for a charge to be a covered medical expense, the service, supply or Pharmaceutical Product must be provided by a provider as defined in paragraph C above. Charges for a service, supply or Pharmaceutical Product provided by a person or facility **not** listed in the definition of provider are **not** covered medical expenses.

The fact that a doctor recommends that a service, supply or Pharmaceutical Product be provided by a person who is not a provider does not make the charge for that service a covered medical expense, even if the care provided is medically necessary. These services, supplies, and Pharmaceutical Products must be medically necessary as defined in this section. No more than the reasonable and customary charge for medical services and supplies and the Scheduled Pharmaceutical Amount for Pharmaceutical Products will be covered by the Plan. *A more detailed description of covered expenses and exclusions follows.*

Substitute the following for item 3. in "P. Reasonable and Customary Charge" under "Meaning of Terms Used" on page 76 of your UnitedHealthcare Certificate.

3. the usual charge of other doctors or other providers in the same or similar geographic area for the same or similar service or supply.

Substitute the following for item S. "Coinsurance" in the "Meaning of Terms Used" section on page 76 of your UnitedHealthcare Certificate.

S. **Coinsurance** means the difference between the reasonable and customary charge or Scheduled Pharmaceutical Amount and the covered percentage under the **Basic Medical** Portion of the Plan. Coinsurance also means the difference between the network allowance and the covered percentage under the **Managed Physical Medicine Program** and the **Home Care Advocacy Program**. You pay the coinsurance.

Substitute the following for item T. 2. a. and T. 2. b. of "Covered Percentage" under "Meaning of Terms Used" on pages 76 and 77 of your UnitedHealthcare Certificate.

2. Under the Basic Medical portion of this Plan, the **covered percentage** for covered medical expenses is **80 percent** of the reasonable and customary charge or the Scheduled Pharmaceutical Amount except:

   a. as provided on page 84 under *"Prospective Procedure Review: MRI"*; on page 85 under *"Home Care Advocacy Program"*; on page 89 under *"Coinsurance and $1,500 Annual Maximum Apply"* for the Managed Physical Medicine Program and on page 91 under *"Infertility Centers of Excellence"*; and

   b. **Effective January 1, 2010. The covered percentage** becomes **100 percent** of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once the coinsurance maximum is met. In calendar year 2010, the coinsurance maximum is $800 for the enrollee, $800 for the enrolled spouse/domestic partner and $800 for all dependent children combined.

      This **Basic Medical Coinsurance Maximum** is adjusted on each January 1 in an amount equal to the percentage increase in the medical care component of the Consumer Price Index for Urban Wage Earners and Clerical Workers, all cities (C.P.I.-W.) for the period July 1 through June 30 of the preceding year.

      Effective January 1, 2010. The 20 percent coinsurance you pay for yourself, your enrolled spouse/domestic partner and for all dependent children combined for covered services by non-participating providers counts toward each respective **coinsurance maximum**. Expenses under the Managed Physical Medicine Program, Mental Health and Substance Abuse Program and Empire BlueCross and BlueShield Hospital Program do not count, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program.

      Once the coinsurance maximum is met, covered medical expenses will be reimbursed at 100 percent of the reasonable and customary or Scheduled Pharmaceutical Amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the reasonable and customary or Scheduled Pharmaceutical Amount and any penalties under the benefits management programs.

Add the following as the last item under "Meaning of Terms Used" on page 77 of your UnitedHealthcare Certificate.

AC. **Nuclear Medicine** means a subspecialty of Radiology best used to demonstrate both image and function of a body organ, as well as its anatomy. It has diagnostic capabilities as well as valuable therapeutic applications and uses very small amounts of radioactive substances, or

tracers, that are attracted to specific organs, bones or tissues, to diagnose or treat disease.

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.

AE. **Pharmaceutical Products** means FDA approved prescription Pharmaceutical Products administered by a doctor or other provider within the scope of the provider's license. Pharmaceutical Products does not include pharmaceuticals that are dispensed to you by a licensed pharmacy, which are subject to the provisions of your prescription drug program.

Substitute the following for "F. Adult Immunizations" under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 79 of your UnitedHealthcare Certificate as amended in your January 2007 Empire Plan Report.

Adult Immunizations

F. **Adult Immunizations** – Immunizations for influenza, pneumonia, measles-mumps-rubella (MMR), vermicelli (chicken pox), and tetanus are covered. Immunization for human papilloma virus (HPV) is covered for females age 19 through 26. **Effective April 1, 2010**, immunizations for Herpes Zoster (shingles) is covered for enrollees and dependents age 55 or older. Covered adult immunizations are subject to an office visit copayment.

Substitute the following for "H. Ambulatory Surgical Center" under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 79 of your UnitedHealthcare Certificate.

Outpatient Surgical Locations

H. **Effective April 1, 2010. Outpatient Surgical Location** – You pay a $30 copayment for facility charges at a freestanding outpatient surgical location that has an Empire Plan agreement in effect with UnitedHealthcare on the date of your elective surgery. The copayment includes anesthesiology, radiology and laboratory tests performed at the outpatient surgical location on the same day as the surgery. You pay an additional $30 copayment for pre-operative testing performed on a different day from the surgery. Surgeon's charges are billed separately and covered under either the Participating Provider or Basic Medical Program provisions.

Substitute the following for item S. under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 80 of your UnitedHealthcare Certificate.

Chronic Care

S. **Chronic Care** – You are covered for chronic care services for chemotherapy, radiation therapy and dialysis. There is no copayment for these chronic care services or for related services rendered during the course of chemotherapy, radiation therapy or dialysis.

Add the following at the end of "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 80 of your UnitedHealthcare Certificate.

Diabetes Education Centers

V. **Diabetes Education Centers** – If you have a diagnosis of diabetes you are covered for visits for self-management education subject to an office visit copayment.

Substitute the following for the first paragraph of "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" under the "Basic Medical Program" on page 81 of your UnitedHealthcare Certificate.

Basic Medical Program

You are responsible for the charges billed by a non-participating provider, and must submit a claim for benefits due.

These benefits are calculated based on the following:

- First, you are liable for the deductible. It is your responsibility.
- After the deductible, covered medical expenses are considered for payment. UnitedHealthcare will reimburse you for 80 percent of the reasonable and customary charges for covered services and supplies or the Scheduled Pharmaceutical Amount, for Pharmaceutical Products, or actual billed charges, whichever is less. You pay the balance of 20 percent (coinsurance) and any charges, above the reasonable and customary or Scheduled Pharmaceutical Amount. The covered percentage becomes 100 percent of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once each coinsurance amount exceeds the coinsurance maximum in a calendar year.

Add the following as the second paragraph of "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" in the "Basic Medical Program" section on page 81 of your UnitedHealthcare Certificate.

You are responsible for the payment of all deductible and coinsurance amounts payable to a non-participating provider after processing of your Basic Medical claim by UnitedHealthcare. Waiver of deductible and co-insurance amounts by a non-participating provider is not permitted under the Basic Medical Program. Prior to receiving services under the Basic Medical benefit, you should discuss with your non-participating provider this requirement and your potential "out-of-pocket" liability. The level of benefits you are entitled to is predicated on meeting all deductible and coinsurance requirements set forth in this Certificate of Insurance. The Plan reserves the right to recover from enrollees benefits paid inconsistent with the provisions of this section of the Certificate of Insurance.

Substitute the following for the first sentence of "A. Annual Deductible" in the "Basic Medical Program" section on page 81 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 $375 for the enrollee, $375 for the enrolled spouse/domestic partner, and $375 for all dependent children combined.

Substitute the following for item "B. Coverage" and "C. Covered Basic Medical Expenses" in "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" under the "Basic Medical Program" on page 81 of your UnitedHealthcare Certificate.

B. **Coverage**

UnitedHealthcare will pay **Basic Medical benefits** to the extent covered medical expenses in a calendar year **exceed the deductible and coinsurance, up to the reasonable and customary or the Scheduled Pharmaceutical Amount.**

C. **Covered Basic Medical Expenses**
Covered medical expenses are defined as the reasonable and customary charge for covered medical services performed or supplies prescribed by a doctor or the Scheduled Pharmaceutical Amount for Pharmaceutical Products provided by a doctor, except as otherwise provided below, due to your sickness, injury or pregnancy. These services, supplies and Pharmaceutical Products must be medically necessary as defined under the Meaning of Terms Used in this Certificate. No more than the reasonable and customary charge or the Scheduled Pharmaceutical Amount for medical services, supplies, and Pharmaceutical Products will be covered by this Plan.

Substitute the following for item B. "Non-network Hospital Program expenses" under "What is covered..." in the "Network and non-network benefits" section under the "Basic Medical Program" on page 82 of your UnitedHealthcare Certificate as amended in your July 2006 Empire Plan Report.

Non-network Hospital Program expenses

B. **Effective January 1, 2010. Non-network Hospital, Skilled Nursing Facility and Hospice Care Facility Out-of-Pocket Expenses** – If The Empire Plan provides your primary coverage and you incur $500 in out-of-pocket expenses under the Hospital Program as the result of using a non-network hospital, skilled nursing facility or hospice care facility for covered services, you may submit a claim to UnitedHealthcare for reimbursement of up to an additional $500 of covered charges for non-network hospital, skilled nursing facility or hospice facility care. This reimbursement is not subject to the Basic Medical deductible or coinsurance. **Any hospital deductibles or coinsurance amounts applied because you failed to meet the requirements of the Benefits Management Program are not reimbursable nor do they count toward the threshold for reimbursement.** You must provide UnitedHealthcare with a copy of your Empire Blue Cross Blue Shield explanation of benefits to document the amount of your covered out-of-pocket expense.

Add the following at the end of "What is covered under the Basic Medical Program (non-participating providers)" in the "Basic Medical Program" section on page 84 of your UnitedHealthcare Certificate.

Prosthetic Wigs

AC. **Effective January 1, 2010. Prosthetic Wigs** – Prosthetic wigs are covered up to the $1,500 lifetime benefit maximum when hair loss is long term and due to a medical condition. These conditions include: disease of the endocrine glands, generalized systemic disease, systemic poisons and hair loss due to radiation therapy, chemotherapy treatment or injury to the scalp. This benefit is not subject to deductible or coinsurance.

Prosthetic wigs are not covered when hair loss is due to male or female pattern baldness.

Diabetes Education Centers

AD. **Diabetes Education Centers – Effective April 1, 2010,** If you have a diagnosis of diabetes you are covered for medically necessary visits for self-management.

Substitute the following for "Prospective Procedure Review MRI" in the "Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review" section on page 84 of your UnitedHealthcare Certificate.

Prospective Procedure Review

Prospective Procedure Review MRI, MRA, CT, PET and Nuclear Medicine tests

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for Prospective Procedure Review before having an elective (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine tests unless you are having the test as an inpatient in a hospital.

If you do not call The Empire Plan before an elective (non-emergency) procedure and UnitedHealthcare's review does not confirm that the procedure was medically necessary, you will be responsible for the full charges.

You do not have to call before an emergency procedure. When UnitedHealthcare receives the claim for the procedure and no call was made, UnitedHealthcare will determine whether the procedure was performed on an emergency basis and whether the procedure was medically necessary.

If you do not call The Empire Plan before a procedure and UnitedHealthcare determines that the procedure was performed on a scheduled (non-emergency) basis and that the procedure was medically necessary, you are liable for the payment of the lesser of 50 percent of the scheduled amounts related to the procedure or $250, plus your copayment, under the Participating Provider Program.

Under the Basic Medical Program, you are liable for the lesser of 50 percent of the reasonable and customary charges related to the procedure or $250. In addition, you must meet your Basic Medical annual deductible and you must pay the coinsurance and any provider charges above the reasonable and customary amount.

Add the following as the second sentence of the first paragraph of "Durable Medical Equipment" under "Durable Medical Equipment and Supplies" in the "Home Care Advocacy Program" section on page 85 of your UnitedHealthcare Certificate.

Durable Medical Equipment

If more than one piece of DME can meet your functional needs, you will receive Benefits only for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Add the following as "6. Diabetic Shoes" under "Network coverage: Paid in full benefit" in the "Home Care Advocacy Program" section on page 86 of your UnitedHealthcare Certificate.

Diabetic Shoes

6. **Diabetic Shoes – Effective January 1, 2010**, You are covered for one pair of medically necessary custom molded or depth shoes per calendar year if you have a diagnosis of diabetes and diabetic foot disease; diabetic shoes have been prescribed by your provider; and the shoes are fitted and furnished by a qualified perdorthist, orthotist, prosthetist or podiatrist. Shoes ordered by mail or from the internet are not eligible for benefits.

   Network coverage - If you use an HCAP-approved provider for medically necessary diabetic shoes, you receive a paid-in-full benefit up to a maximum annual benefit of $500 per year. You must make a pre-notification call to HCAP to receive paid-in-full network benefits.

   Non-network coverage - If you do not use an HCAP-approved provider for medically necessary diabetic shoes Basic Medical benefits apply subject to deductible with any remaining covered charges covered at 75 percent of the network allowance with a maximum annual benefit of $500.

Substitute the following for the second paragraph of "What is covered?" under "Centers of Excellence for Cancer Program" on page 183 of the January 2007 amendments to your UnitedHealthcare Certificate.

Cancer Program

When the above services have been authorized by CRS and provided at a CRS Center of Excellence facility, you will not have to make any copayments for services rendered at the Center. Also, once enrolled in the Program, when the facility is more than 100 miles (200 miles for airfare) from the patient's home, a travel and meals benefit is available to the patient and one travel companion. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the

following travel expenses are reimbursable: meals, auto mileage (personal or rental car), economy class airfare, train fare, taxi fare, parking, tolls and shuttle or bus fare from lodging to the Center of Excellence.

Substitute the following for the last bullet of "...prior authorization for Qualified Procedures" under "Infertility Benefits" on page 91 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).

Exclusions

In all instances where the terms "services and/or supplies", "services or supplies" or "services" are used, replace them, respectively, with "services, supplies and/or Pharmaceutical Products", "services, supplies or Pharmaceutical Products", and "services or Pharmaceutical Products" in the "Exclusions" section of "UnitedHealthcare General Provisions" on pages 91-93 of your UnitedHealthcare Certificate.

Substitute the following for items 1. and 3. in the "Coordination of Benefits" section of "UnitedHealthcare General Provisions" on pages 93 and 94 of your UnitedHealthcare Certificate.

Coordination of Benefits

1. **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 reasonable and customary charge for a service or the Scheduled Pharmaceutical Amount for Pharmaceutical Products covered under both group plans.

3. 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 reasonable and customary charge for the service or the Scheduled Pharmaceutical Amount or Pharmaceutical Product you receive.

Add the following as the last paragraph of "Coordination of Benefits (COB)" on page 95 of your UnitedHealthcare Certificate.

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 second paragraph of item A. in the "Impact of Medicare on this Plan" section of "UnitedHealthcare General Provisions" on page 95 of your UnitedHealthcare Certificate.

Medicare

When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations rather than the Participating Provider Scheduled Allowances, the Reasonable and Customary Charge or the Scheduled Pharmaceutical Amount as defined in the Meanings of Terms used.

Add the following as item F. under "Coverage" in the "Impact of Medicare on this Plan" section on page 95 of your UnitedHealthcare Certificate.

Medicare Coverage

F. ***If you or your dependents are eligible and enrolled for 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.

Substitute the following for item A. and the first paragraph of item B. of "How" and items A. and B. of "When" under "How, When and Where to Submit Claims" on page 97 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 100 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 104-128 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. **UHIC-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 $20 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.

C. You pay the first $20 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 $375 per enrollee, $375 per covered spouse/domestic partner and $375 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 $800 for the enrollee, 800 for the enrolled spouse/dependent partner and $800 for all dependent children combined.

   The annual deductible and annual coinsurance maximum will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I) for Urban Wage Earners and Clerical Workers, all Cities, C.P.I.-W) for the period of July 1 through June 30 of the preceding year. Deductibles do not count towards the coinsurance maximum.

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 the following for the Empire BlueCross BlueShield Certificate of Insurance on pages 129-142 of your Empire Plan Certificate.

Certificate of Insurance

CERTIFICATE OF INSURANCE
for eligible enrollees of State of New York
(called the State)
insured by
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
Hauppauge, New York
(called UnitedHealthcare)

UnitedHealthcare Insurance Company of New York has issued Group Policy No. 712959-G. It insures certain eligible enrollees covered by The Empire Plan.

This Certificate of Insurance describes the benefits and provisions of the policy. This is a covered person's Certificate of Insurance only while that person is insured under the policy. Dependent benefits apply only to eligible dependents covered under an enrollee's family coverage if the eligible enrollee is insured under The Empire Plan for family coverage.

This Certificate describes the Plan in effect on the later of:

A. January 1, 2010 and

B. The date determined in accordance with the Regulations of the President of the Civil Service Commission

for Employees of the State of New York and their Dependents enrolled in The Empire Plan through New York State Correctional Officers and Police Benevolent Association (NYSCOPBA) who are subject to the binding arbitration award issued on April 30, 2009 and for COBRA enrollees with their benefits. It is void if issued to any other Employee.

This Certificate replaces any and all Certificates previously issued to eligible enrollees under the Plan.

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Form No. 712959

UNITEDHEALTHCARE
CERTIFICATE OF INSURANCE
Empire Plan Prescription Drug Program
Section V
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
CERTIFICATE OF INSURANCE
Empire Plan Prescription Drug Program

UnitedHealthcare Insurance Company of New York (the "Insurer") insures and jointly administers The Empire Plan Prescription Drug Program (the "Program"). UnitedHealthcare utilizes the administrative and mail distribution services of Medco Health Solutions, Inc. (Medco).

Meaning of Terms Used

The following terms used in this Certificate with either upper or lower case initial letters shall have the following meanings.

A. **Appeal** means a request for review of your claim in the event a claim has been denied as not medically necessary or as a result of investigational or experimental use of a covered prescription drug in whole or in part.

B. **Brand-Name Drug** means a prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition.

C. **Compound Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s)** means a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA approved covered drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by this Program.

D. **Controlled Drug** means drugs designated by Federal Law or New York State law as a Class I, II, III, IV or V substance. A Controlled Drug includes but is not limited to: some tranquilizers; stimulants; and pain medications.

E. **Designated Specialty Pharmacy** means a pharmacy that has entered into an agreement with Medco to provide specific Specialty Drugs/Medications. The Empire Plan's Designated Specialty Pharmacy is Accredo Pharmacy.

F. **Doctor** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), who is legally licensed, without limitations, to practice medicine. For benefits provided under this certificate, and for no other purpose, Doctor also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

G. **Exception** means a request for review of a previous decision made by The Empire Plan Prescription Drug Program that does not involve denial based on medical necessity or as a result of an investigational or experimental use of a covered prescription drug in whole or in part.

H. **Excluded Drug:** A drug that is excluded from coverage under this Program's benefit plan design. This Program will provide no benefit for an excluded drug and you will be responsible for paying the total retail cost of the drug. An excluded drug is not subject to any type of appeal or coverage review, including a medical necessity appeal.

I. **First Fill** means an enrollee's initial or very first dispensing of a Specialty Drug/Medication covered under The Empire Plan Specialty Pharmacy Program.

J. **Flexible Formulary:** In a flexible formulary, Brand-Name Drugs may be assigned to different copayment levels based on value to this Program and clinical judgment. In some cases, drugs may be excluded from coverage if a Therapeutic Equivalent is covered or available as an over-the-counter drug.

K. **Generic Drug** means a drug sold under its chemical name or sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term Generic Drug shall include authorized generics marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs shall be classified as a Generic Drug.

L. **Grace Period for Specialty Drugs** means a period of time during which an enrollee is allowed to have one fill of a Specialty Drug/Medication dispensed from a Pharmacy other than the Designated Specialty Pharmacy.

M. **Mail Service Pharmacy** means all facilities that are owned, operated or affiliated with Medco to fill enrollee prescriptions for all drugs covered by the Program through the mail service pharmacy process including Medco Pharmacy. Medco Pharmacy shall dispense drugs per the terms of this Certificate and in accordance with the laws, rules and regulations that govern pharmacy practice.

N. **Medically Necessary Drug** means any drug that, as determined by the Insurer, is:

1. Provided for the diagnosis or treatment of a medical condition;
2. Appropriate for the symptoms, diagnosis or treatment of a medical condition;
3. Within the standards of generally accepted health care practice; and
4. Not used for cosmetic purposes.

If your claim is denied for benefits for a drug or drugs on the basis that the drug is not medically necessary, benefits will be paid under The Empire Plan Prescription Drug Program if the drug is covered under your benefit plan design and:

- Another Empire Plan carrier has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug, and has paid benefits in accordance with Empire Plan provisions on your behalf for a medical procedure or service related to the administration of that drug; or
- Another Empire Plan carrier has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug, and has provided to you a written pre-authorization of benefits based on their determination

of medical necessity, stating that The Empire Plan benefits will be available to you for a medical procedure or service related to the administration of that drug; and

- You provide to the Program proof of payment or pre-authorization of benefits from the other Empire Plan carrier based on their determination of medical necessity regarding the availability of Empire Plan benefits to you for a medical procedure or service related to the administration of that drug.

In addition, the above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

O. **Network Pharmacy** means a Pharmacy, other than a Mail Service Pharmacy or the Designated Specialty Pharmacy, that has entered into a contract with Medco as an independent contractor to dispense drugs per the terms of the contract. It must regularly dispense drugs described in the "*What is Covered*" section.

P. **No-Fault Motor Vehicle Plan** means a motor vehicle plan that is required by law. It provides medical or dental care payments that are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

Q. **Non-Network Pharmacy** means any Pharmacy, other than a Mail Service Pharmacy, that has not entered into a contract with Medco to dispense drugs. The Enrollee must file a claim form with the Insurer in order to receive reimbursement for covered drugs received from a Non-Network Pharmacy.

R. **Non-Preferred Brand-Name Drug** means a Brand-Name Drug that has not been placed in Level 1 or Level 2 on The Empire Plan Flexible Formulary drug list by the Insurer.

S. **Pharmacist** means a person who is legally licensed to practice the profession of pharmacy. He or she must regularly practice such profession in a pharmacy.

T. **Pharmacy** means an establishment that is registered as a pharmacy with the appropriate state licensing agency or is a Veterans' Affairs medical center or hospital pharmacy, and regularly dispenses medications that require a Prescription from a Doctor. Drugs described in the section *"What Is Covered"* must be regularly dispensed from the Pharmacy by a Pharmacist.

U. **Preferred Brand-Name Drug** means a Brand-Name Drug that has been placed on The Empire Plan Flexible Formulary drug list by the Insurer.

V. **Prescription** means the written or oral request for drugs issued by a Doctor duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

W. **Program** means The Empire Plan Prescription Drug Program described in this Certificate.

X. **Specialty Drugs/Medications** mean drugs that treat rare disease states; require special handling, special administration or intensive patient monitoring/testing; biotech drugs developed from human cell proteins and DNA targeted to treat disease at the cellular level or other drugs used to treat patients with chronic or life threatening diseases.

Y. **Therapeutic Category** means categories by which drugs are identified and grouped by the main conditions they treat.

Z. **Therapeutic Equivalent** means prescription drug products that, when compared, can be expected to produce essentially the same therapeutic outcome and toxicity as determined by the Insurer.

AA. **Workers' Compensation Law** means a law that requires employees to be covered, at the expense of the employer, for benefits in case they are disabled because of accident or sickness or billed due to a cause connected with their employment.

AB. **You, your,** or **yours** refers to you, the eligible enrollee to whom this Certificate is issued. It also refers to your eligible enrolled dependents who are covered under this Program. For information on eligibility, refer to your *New York State Health Insurance Program General Information Book*.

The information below explains your benefits and responsibilities in detail.

Your Benefits and Responsibilities

Copayments

Copayments for covered drugs are based on the drug, the days' supply and whether the Prescription is filled at a Network Pharmacy or a Mail Service Pharmacy or the Designated Specialty Pharmacy.

When you fill your Prescription for a covered drug for up to a **30-day supply at a Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy,** your copayment is:

- **$5** for a **Generic** Drug or a Level 1 Drug
- **$15** for a **Preferred Brand-Name** Drug, Compound Drug or a Level 2 Drug
- **$40** for a **Non-Preferred Brand-Name** Drug, or a Level 3 Drug

When you fill your Prescription for a **31- to 90-day supply at a Network Pharmacy**, your copayment is:

- **$10** for a **Generic** Drug or a Level 1 Drug
- **$30** for a **Preferred Brand-Name** Drug, Compound Drug or a Level 2 Drug
- **$70** for a **Non-Preferred Brand-Name** Drug or a Level 3 Drug

When you fill your Prescription for a **31- to 90-day supply through a Mail Service Pharmacy or the Designated Specialty Pharmacy**, your copayment is:

- **$5** for a **Generic** Drug or a Level 1 Drug
- **$20** for a **Preferred Brand-Name** Drug, Compound Drug or a Level 2 Drug
- **$65** for a **Non-Preferred Brand-Name** Drug or a Level 3 Drug

One copayment covers up to a 90-day supply. Refills are valid for up to one year from the date the Prescription is written.

If the full cost of the drug is less than your copayment, your cost is the lesser amount.

Supply and Coverage Limits

Certain drugs may be subject to quantity level limits based on clinical and safety factors related to the dispensing of the medication. Additional quantity level limits are based on criteria developed by the Insurer. Days supply for Controlled Drugs are in accordance with Federal and State mandates.

Erectile dysfunction drugs are limited to a specific quantity per day supply; 6 units for a 30-day supply and 7-18 units for a 31- to 90-day supply. Specialty Drugs/Medications may be dispensed for up to a 90-day supply when clinically appropriate. Certain Specialty Drugs/Medications may only be dispensed for up to a 30 day supply due to clinical/dispensing guidelines.

Mandatory Generic Substitution

When your Prescription is written Dispense As Written (DAW) for 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 and the Generic Drug, not to exceed the full retail cost of the drug. When your Prescription is not written DAW, in most cases, the generic equivalent is substituted for the Brand-Name Drug and you pay the Generic Drug copayment.

The following Brand-Name Drugs are excluded from mandatory generic substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid and Tegretol. For these drugs, you pay only the applicable copayment, which in most cases will be the Non-Preferred Brand-Name copayment.

If your Doctor believes it is Medically Necessary for you or your family member to have a Brand-Name Drug (that has a generic equivalent), you may appeal the mandatory generic substitution requirement. To begin the appeal process, your Doctor should call toll free 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

Act promptly. If your appeal is approved, upon request, the Insurer will adjust claims processed by a pharmacy within 30 days from the date the Insurer received all information needed to decide the appeal.

If your appeal is granted and you fill your prescription for a Brand-Name Drug at a Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy, you pay the Non-Preferred copayment. If your appeal is denied, you can make a second appeal to the Insurer.

Empire Plan Flexible Formulary

Under The Empire Plan Flexible Formulary plan design drugs are classified by therapeutic category or medical condition in order to manage prescription costs without affecting the quality of care. A therapeutic category is a group of drugs that treat a specific health condition or that work in a certain way. For example, antibiotics are used for the treatment of infections.

Drugs on The Empire Plan Flexible Formulary are grouped into Levels and your copayment is determined by the "Level" that your medication is on.

A. Level 1 drugs have the lowest copayment and include all covered Generic Drugs and certain Brand-Name drugs.

B. Level 2 drugs have the mid-range copayment and include Preferred Brand-Name Drugs that have been selected because of their overall healthcare value.

C. Level 3 drugs have the highest copayment and include Non-Preferred Brand-Name Drugs.

The Flexible Formulary works with The Empire Plan Prescription Drug Program plan design as described below:

A. When clinically appropriate and financially advantageous to this Program, Brand-Name Drugs may be available on Level 1;

B. Certain therapeutic categories of prescription drugs with two or more clinically sound and therapeutically equivalent Level 1 options may not have a Brand-Name Drug in Level 2; and

C. Access to one or more drugs in select therapeutic categories may be excluded (not covered) if the drug(s) has no clinical advantage over other Generic Drug(s) and Brand-Name Drug(s) in the same therapeutic category.

   Drugs considered to have no clinical advantage that may be excluded include any products that:

   1. Contain one or more active ingredients available in and therapeutically equivalent to another covered prescription drug in the therapeutic category or in an over-the-counter drug; or

   2. Contain one or more active ingredients which is a modified version of and therapeutically equivalent to another covered prescription drug or in an over-the-counter drug.

Please refer to the Exclusions and Limitations section of the Certificate for a list of drugs not covered by The Empire Plan Prescription Drug Program.

Periodically, the Program may offer enrollees taking certain prescription medications covered under the benefit design an instant rebate of the copayment for that particular prescription drug.

Prior authorization required for certain drugs

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for certain medications. If your Doctor prescribes one of these drugs, the Insurer will request from your Doctor the clinical information required to authorize coverage of the medication. Your Pharmacy or Doctor may contact the Insurer to begin the authorization process. The Insurer and/or pharmacy will notify you of the results of the review. The prior authorization requirements apply whether you use your Empire Plan Benefit Card or will be filing a claim for direct reimbursement. The following is a list of drugs (including generic equivalents) that require prior authorization:

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

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds $100 will require Prior Authorization under this Program. This list of drugs is subject to change. For the most current list of drugs requiring prior authorization, call The Empire Plan Prescription Drug Program at the number below or go to the New York State Department of Civil Service web site at https://www.cs.state.ny.us. For more information about drugs requiring prior authorization and how to obtain it, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

If the prior authorization review results in authorization for payment, you will receive Empire Plan Prescription Drug Program benefits for the drug. If the payment is not authorized, no Empire Plan Prescription Drug Program benefits will be paid for the drug.

An appeal process allows you or your Doctor to ask for further review if authorization is not granted. You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program for information on how to initiate an appeal.

Specialty Pharmacy Program

Under the Empire Plan Specialty Pharmacy Program, when your physician prescribes a covered Specialty Drug/Medication you may be directed to the Designated Specialty Pharmacy to obtain benefits under the Program.

The Program requires certain Specialty Drugs/Medications be dispensed by the Designated Specialty Pharmacy. When initiating therapy with a Specialty Drug/Medication you may send your prescription directly to the Designated Specialty Pharmacy to start receiving specialty program benefits. Otherwise,

you are allowed one Grace Period for Specialty Drugs, during which the Program will cover the First Fill of your medication at any Network Pharmacy with the applicable copayment.

After your First Fill, you are covered for subsequent fills of your Specialty Drug/Medication when dispensed by the Designated Specialty Pharmacy. You will be charged the Mail Service copayment for covered Specialty Drugs/Medications dispensed by the Designated Specialty Pharmacy.

The Empire Plan Specialty Drug/Medication list is subject to change without notice. To view the most current list go to the NYS Department of Civil Service web site at https://www.cs.state.ny.us or call The Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP (1-877-769-7447).

If you pay the full cost of your Specialty Drug/Medication at a Pharmacy other than the Designated Specialty Pharmacy, you will be required to file a claim for reimbursement. You will not be reimbursed the total amount you paid for the Prescription and your out-of-pocket expense may exceed the usual Mail Service copayment amount.

What is Covered

You are covered for the following prescription drugs or medicines when they are covered under this Program's benefit design, Medically Necessary and dispensed by a Pharmacy:

A. FDA approved drugs that must bear the legend: RX Only.
B. State Restricted Drugs. Drugs or medicines that can be dispensed in accordance with New York State Law (or by the laws of the state or jurisdiction in which the Prescription is filled) by Prescription only.
C. Compound Drug(s)/Medication(s).
D. Injectable insulin.
E. First Fill of a Specialty Drug/Medication filled at a Network Pharmacy and subsequent fills processed by the Designated Specialty Pharmacy.
F. Oral, injectable or surgically implanted contraceptives that bear the legend RX Only, diaphragms and contraceptive devices.
G. Vitamins, which are FDA approved prescription drugs and bear the legend RX Only.
H. Covered prescription drugs dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility; rest home; sanitarium; extended care facility; convalescent hospital; or similar facility. Such on-premises pharmacies are considered Non-Network Pharmacies and require submission of a claim form for reimbursement.
I. Claims for drugs dispensed outside of the U.S. that have an available U.S. FDA approved equivalent.

Please refer to the section *"Exclusions and Limitations"* below for conditions under which benefits for the above are not available.

Exclusions and Limitations

Charges for the following items are **not** covered expenses:

A. Drugs obtained with no prescription order, including over the counter products except insulin.
B. Drugs taken or given at the time and place of the prescription order and billed by the Doctor.
C. Drugs provided or required by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay.
D. Drugs for which there is no charge or legal obligation to pay in the absence of insurance.

E. Drugs administered to you by the facility while a patient in a licensed hospital

This limit applies only if the hospital in which you are a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals; and dispenses such drugs administered to you by the hospital.

F. Any drug refill that is more than the number approved by the Doctor.

G. Contraceptive jellies, ointments and foams or devices not requiring a Doctor's order, prescribed for any reason.

H. Contraceptive Intrauterine Devices (I.U.D.) that do not contain any FDA approved hormone prescription drug products.

I. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments or other non-medicinal substances), regardless of their intended use.

J. The administration of any drug or injectable insulin.

K. Any drug refill that is dispensed more than one year after the original date of the prescription order.

L. Any drug labeled "Caution: Limited by Federal Law to Investigational Use," or experimental drugs except for drugs used for the treatment of cancer as specified in Section 3221(l)12 of New York State Insurance Law as may be amended from time to time: Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or any drug that the U.S. Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Experimental or investigational drugs shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. For external appeal provisions, see *"Your right to an External Appeal"* under Miscellaneous Provisions. If the External Appeal Agent approves coverage of an experimental or investigational drug that is part of a clinical trial, only the costs of the drug will be covered. Coverage will not be provided for the costs of experimental or investigational drugs or devices, the costs of non-health care services, the costs of managing research or costs not otherwise covered by The Empire Plan for non-experimental or non-investigational drugs provided in connection with such clinical trial.

M. Immunizing agents, biological sera, blood or blood plasma, except immune globulin.

N. Any drug that a Doctor or other health professional is not authorized by his or her license to prescribe.

O. Drugs for an injury or sickness related to employment for which benefits are provided by any State or Federal workers' compensation, employers' liability or occupational disease law or under Medicare or other governmental program, except Medicaid.

P. Drugs purchased prior to the start of coverage or after coverage ends.

However if the person is totally disabled on the date this insurance ends, see *"Benefits after termination of coverage"*.

Q. Any drug prescribed and/or dispensed in violation of State or Federal law.

R. Prescription drug products excluded from the benefit plan design, including: Adoxa, Amrix, Asocol HD, Caduet, Clobex Shampoo, Coreg CR, Detrol LA, Doryx, Flector, Genotropin (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Humatrope (except for the treatment of growth failure due to SHOX

deficiency or Small for Gestational Age), Kapidex, lansoprazole, Nexium, Norditropin (except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age), Olux/Olux-E Complete Pack, Omnitrope, Prevacid Capsules, Requip XL, Soma 250, Testim, Treximet, Veramyst and Xopenex Inhalation Solution.

S. New Prescription Drug Products that are in the same therapeutic category as existing drugs excluded under The Empire Plan Flexible Formulary or that are in the same therapeutic category as drugs excluded from benefit coverage under this Plan. Please refer to the New York State Department of Civil Service web site at https://www.cs.state.ny.us or call The Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP) (1-877-769-7447) for current information regarding exclusions of newly launched prescription drugs.

T. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include but are not limited to:

1. Non-amphetamine anorexiants, except for morbid obesity
2. Amphetamines that are prescribed for weight loss, except for morbid obesity
3. Products used to promote hair growth
4. Products (ex. Retinoic Acid) used for prevention of skin wrinkling

U. Coverage for drugs where the amount dispensed exceeds the supply limit.

V. Coverage for drugs as a replacement for a previously dispensed drug.

W. Products for which the primary use is nutrition.

X. Any non-medically necessary drugs.

Y. Claims for foreign drugs for which there is no available US equivalent approved by the FDA.

IMPORTANT: See your *NYSHIP General Information Book and Empire Plan Certificate* for other conditions that may affect this coverage. See especially the Home Care Advocacy Program (HCAP) section of your UnitedHealthcare Certificate for coverage for prescription drugs billed by a home care agency.

How to Use Your Empire Plan Prescription Drug Program

When your Doctor prescribes a Medically Necessary Drug covered under The Empire Plan, you can fill the prescription for a supply of up to 90 days and refills for up to one year in one of three ways: at a Network Pharmacy, at a Non-Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy.

When your Doctor starts you on a new medication, you may want to have your prescription filled for a 30-day supply to ensure the prescription medication is right for your condition.

Network Pharmacies

You can use your Empire Plan Benefit Card for covered prescription drugs at Empire Plan Network Pharmacies. Be sure your Pharmacist knows that you and your family have Empire Plan Prescription Drug Program coverage.

To find a Network Pharmacy, check with your Pharmacist or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program or go to the web site at https://www.cs.state.ny.us.

Many retail pharmacies in New York State participate in this Program. Many out-of-State pharmacies participate, as well. All Empire Plan Network Pharmacies can fill Prescriptions for supplies of up to 90 days. Refills of covered drugs are provided for up to a year from the date the Prescription is written. Only one copayment applies for up to a 90-day supply.

Non-Network Pharmacies

You can use a Non-Network Pharmacy or pay the full amount for your Prescription at a Network Pharmacy (instead of using your Empire Plan Benefit Card) and fill out a claim for reimbursement.

In almost all cases, you will not be reimbursed the total amount you paid for the Prescription and your out-of-pocket expenses may exceed the usual copayment amount. To reduce your out-of-pocket expense, use your Empire Plan Benefit Card whenever possible.

Out-of-pocket expenses: When you use a Non-Network Pharmacy or pay the full amount for your Prescription at a Network Pharmacy, you are responsible for the difference between the amount charged and the amount you are reimbursed under this Program.

For claim forms, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program or download one from the web site at https://www.cs.state.ny.us.

Mail the completed form with your bills or receipts to:

Medco Health Solutions
P.O. Box 14711
Lexington, KY 40512

Several factors affect the amount of your reimbursement. If your Prescription was filled with:

- A Generic Drug, a Brand-Name Drug with no generic equivalent or insulin, you will be reimbursed up to the amount this Program would reimburse a Network Pharmacy for that Prescription as calculated using the Program's standard reimbursement rate for Network Pharmacies less the applicable copayment.
- A Brand-Name Drug with a generic equivalent (other than drugs excluded from mandatory generic substitution), you will be reimbursed up to the amount this Program would reimburse a Network Pharmacy for filling the Prescription with that drug's generic equivalent as calculated using the Program's standard reimbursement rates for Network Pharmacies less the applicable copayment, which in most cases will be the Non-Preferred copayment.

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).

Mail Service Pharmacy or the Designated Specialty Pharmacy

All drugs covered by the Program can be ordered through a Mail Service Pharmacy or the Designated Specialty Pharmacy.

You can order and receive up to a 90-day supply of your Prescriptions, shipped by first class mail or private carrier. You can pay your copayment(s) and other costs by credit card, check or money order. To request mail service envelopes, refills or to speak to a Pharmacist about your mail service Prescription, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program, 24 hours a day, seven days a week.

The Mail Service Pharmacy or the Designated Specialty Pharmacy address is:

Medco Pharmacy
P.O. Box 6500
Cincinnati, OH 45201-6500

Using The Empire Plan Flexible Formulary drug list

One way you can help control the rapidly increasing cost of prescription drugs is to encourage your Doctor(s) to prescribe and Pharmacist to dispense covered Generic and Preferred Drugs listed on The Empire Plan Flexible Formulary drug list. (The Empire Plan Flexible Formulary drug list is available at https://www.cs.state.ny.us.) This is not a complete list of all prescription drugs on the flexible formulary or covered under The Empire Plan. This list and excluded medications are subject to change. New prescription drugs may be subject to exclusion when they become available in the market.

This list provides the most commonly prescribed Generic and Brand-Name Drugs included on The Empire Plan Flexible Formulary drug list. These medications are safe and effective alternatives to higher cost drugs. Using Prescription drugs that appear on this list will save you money. Using Generics will save you even more.

The Insurer will provide the Flexible Formulary drug list to you and to Empire Plan participating Doctors. Doctors are encouraged - but not required - to use this list.

Remember, if your Doctor prescribes a prescription drug that is excluded from coverage under The Empire Plan benefit plan design, you will pay the full retail cost for your prescription.

Help control the rising cost of the prescription drug program by asking your Doctor to prescribe a covered drug that is appropriate for you from the Flexible Formulary drug list.

Half Tablet/Pill Splitting Program

The Half Tablet Program provides an opportunity for you to reduce your prescription medication copayments for certain eligible medications by using double strength tablets and splitting them in half.

This program is voluntary.

To participate in the Half Tablet Program, ask your Doctor to write a new Prescription for an eligible medication for twice the dosage and half the quantity, with directions to take half the tablet at the regularly scheduled time. When the Prescription is filled at either a Network pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy, the copayment is automatically cut in half. For an updated list of the medications eligible for the Half Tablet Program, go to https://www.cs.state.ny.us and select Benefits Programs in the left-hand navigation on the home page. Follow the prompts to NYSHIP Online, then choose Find a Provider. Scroll to the Medco links and click Empire Plan Half Tablet Program.

Contact The Empire Plan Prescription Drug Program

For questions about your Empire Plan Prescription Drug Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program. The Teletypewriter (TTY) number for callers with a hearing or speech disability is 1-800-759-1089.

Call 24 hours a day, 7 days a week if you need to:

- Verify your eligibility
- Find out if your claims have been paid
- Locate an Empire Plan Network Pharmacy
- Order refills from a Mail Service Pharmacy or the Designated Specialty Pharmacy or check order status
- Talk to a customer service representative
- Request prior authorization or a generic appeal
- Talk to a Pharmacist

Go to https://www.cs.state.ny.us, select Benefit Programs and follow the prompts to NYSHIP Online. Then choose Find a Provider and scroll to the Medco links if you need to:

- Locate an Empire Plan Network Pharmacy
- Order refills online from Medco Pharmacy or check order status
- Order refills online from the Designated Specialty Pharmacy and check order status
- Download a Medco Pharmacy order form
- View the list of drugs subject to prior authorization or eligible for the Half Tablet Program
- View the Flexible Formulary drug list

Coordination of Benefits

A. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan Prescription Drug Program are coordinated with the benefits provided for you under another group 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 total allowable charge for a service covered under both group plans.

If a covered drug is submitted under the Program, the Program will reimburse the enrollee the submitted balance or the amount that would have been paid as a network benefit under The Empire Plan, whichever is lower. In addition, if you or any of your dependent(s) is covered under two separate Empire Plan policies, you may submit Empire Plan copayments for reimbursement under your secondary Empire Plan coverage using a paper claim form.

B. **Definitions**

1. **Plan** means a plan that provides benefits or services for or by reason of medical or dental care and that 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 that 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.
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 that 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 that 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 total allowable charge 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 a Coordination of Benefits or

similar provision with the same order of benefit determination as stated in Item E. and under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.

E. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules that applies:

1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that 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 that has covered one parent for a longer period of time are determined before those of the plan that 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; and
   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. Finally, the plan of the parent not having custody of the child; and
   d. 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 knowledge.
4. The benefits of a plan that covers 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 that 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 that 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 that is needed to apply this provision may be given or received without the consent of or notice to any person, except as required by 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, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.

I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts that are considered proper under this provision.

Medicare Prescription Drug Coverage

If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, read the following information about how to use your Empire Plan benefits for secondary coverage.

A Medicare-primary Empire Plan enrollee or dependent enrolled in a Medicare Part D drug plan must use his or her Medicare Part D prescription drug program first. Any amounts not covered by your Medicare Part D plan, such as deductibles, copayments and charges for non-covered drugs, can be submitted to The Empire Plan for consideration using The Empire Plan Prescription Drug Program claim form specifically labeled Medicare Part D Secondary Claim Form. This claim form is available on the New York State Department of Civil Service web site, https://www.cs.state.ny.us. The form is also available by calling The Empire Plan Prescription Drug Program at 1-877-7-NYSHIP (1-877-769-7447). When you call, be sure to ask for the Medicare Part D claim form.

At Network Pharmacies: Any claim submitted to The Empire Plan Prescription Drug Program by a Network Pharmacy will be rejected and the Pharmacist will be advised that you have alternate insurance, which is your Medicare Part D drug plan. You are responsible for providing the Pharmacist with the necessary Medicare Part D plan information to submit the claim. Then, you must follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

At Mail Service Pharmacies or the Designated Specialty Pharmacy: Any prescription sent to a Mail Service Pharmacy or the Designated Specialty Pharmacy for a Medicare-primary Empire Plan enrollee or dependent who is also enrolled in a Medicare Part D drug plan will be rejected and returned. You must use your Medicare Part D drug plan first and then follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

IMPORTANT: If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, you must submit your out-of-pocket expenses to The Empire Plan Prescription Drug Program using The Empire Plan Prescription Drug Program Medicare Part D Secondary Claim Form only. Your claim will be processed in accordance with the coordination of benefits provisions of The Empire Plan Prescription Drug Program. If you use the standard Empire Plan Prescription Drug Program claim form, your claim will be rejected and you will have to resubmit it using the Medicare Part D Secondary Claim Form.

Miscellaneous Provisions

Termination of coverage

A. Coverage will end when you are no longer eligible to participate in this Program. Refer to the eligibility section of your *NYSHIP General Information Book*.

   Under certain conditions, you may be eligible to continue coverage under The Empire Plan temporarily after eligibility ends. Refer to the COBRA section of your *NYSHIP General Information Book*.

B. If this Program ends, your Program 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*.

   Under certain conditions, dependent(s) of employees or former employees may be eligible to continue coverage under The Empire Plan temporarily after eligibility ends. Refer to the COBRA section of your *NYSHIP General Information Book*.

D. If a payment that is required from you toward the cost of The Empire Plan coverage is not made, the coverage will end on the last day of the period for which a payment was made.

E. If coverage ends, any claim incurred before your coverage ends for any reason will not be affected; also, see *"Benefits after termination of coverage"* below.

Benefits after termination of coverage

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.

Totally Disabled means that because of a sickness or injury you, the enrollee, cannot do your job, or any other work for which you might be trained, or your dependent cannot do his or her usual duties.

Request for repayment of benefits

The Insurer will seek reimbursement from you for any money paid on behalf of you or your dependents for expenses incurred after loss of eligibility for benefits for any reason. Use of The Empire Plan Benefit Card after eligibility ends constitutes fraud.

Audits/prescription benefit records

From time to time, the Insurer may ask you to verify receipt of particular drugs from Network Pharmacies or from a Mail Service Pharmacy or the Designated Specialty Pharmacy. These requests are part of the auditing process. Your cooperation may be helpful in identifying fraudulent practices or unnecessary charges to your plan. All such personal information will remain confidential.

Legal action

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

Appeals and Coverage Exceptions

Coverage Exceptions: Flexible Formulary

Coverage for prescription drugs excluded and/or limited in quantity under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under The Empire Plan Flexible Formulary.

Non-Preferred Brand-Name Drugs covered under the Program are subject to the Level 3 copayment. Under the Program benefit design, copayment exceptions are not permitted.

Claims appeal: 60-day deadline

In the event a claim has been denied as not medically necessary or as a result of investigational or experimental use of a covered prescription drug, you can request a review of your claim. This request for review should be sent to the Claims Review Unit at the following address within 60 days after you receive notice of denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data questions or comments you deem appropriate.

To request a review of your claim, write to:

The Empire Plan Prescription Drug Program
UnitedHealthcare
P.O. Box 5900
Kingston, NY 12402-5900

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, NY 12257. Phone: 1-800-342-3736, Monday - Friday, 9 a.m. – 5 p.m.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Insurer has denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug, 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 drug is not medically necessary

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

A. The prescription drug must otherwise be covered under The Empire Plan Prescription Drug Program; and

B. You must have received a final adverse determination through the internal appeal process described above and the Insurer must have upheld the denial or you and the Insurer must agree in writing to waive any internal appeal.

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

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

A. The prescription drug must otherwise be covered under The Empire Plan Prescription Drug Program; and

B. You must have received a final adverse determination through the internal appeal process described above and the Insurer must have upheld the denial or you and the Insurer must agree in writing to waive any internal appeal.

In addition, your attending Doctor must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one that, according to the current diagnosis of your attending Doctor, 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 Doctor must also certify that your life-threatening or disabling condition or disease is one for which standard drugs are ineffective or

medically inappropriate **or** one for which there does not exist a more beneficial standard drug or procedure covered by the Program.

In addition, your attending Doctor must have recommended a drug that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered drug. (Only certain documents will be considered in support of this recommendation. Your attending Doctor should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable.)

For the purposes of this section, your attending Doctor 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 prescription drug is not medically necessary or is an experimental or investigational drug, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Insurer 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. The Insurer will provide an external appeal application with the final adverse determination issued through the Insurer'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 the Insurer based its denial, the External Appeal Agent will share this information with the Insurer in order for it to exercise its right to reconsider its decision. If the Insurer chooses to exercise this right, the Insurer will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Insurer 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 Doctor or the Insurer. 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 Doctor certifies that a delay in providing the prescription drug 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 the Insurer 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 the Insurer's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, the Insurer will provide coverage subject to the other terms and conditions of the Program.

The External Appeal Agent's decision is binding on both you and the Insurer. 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. The Insurer 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 Doctor 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 the Insurer that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Insurer has no authority to grant an extension of this deadline.

More About Your Empire Plan Prescription Drug Program

Drug Utilization Review (DUR)

Prescription drugs can work wonders in curing ailments and keeping you healthy — often at a cost much lower than surgery or other procedures. But they can also cause serious harm when taken in the wrong dosage or in a harmful combination with another drug.

DUR identifies possible problems

Your Empire Plan Prescription Drug Program includes a Drug Utilization Review (DUR) program to check for possible inappropriate drug consumption, medical conflicts or dangerous medication interactions.

The DUR process

This review process generally asks:

- Is the Prescription written for the recommended daily dose?
- Is the patient already taking another drug that might conflict with the newly prescribed drug?
- Does the patient's prescription drug record indicate a medical condition that might be made worse by this drug?
- Has the age of the patient been taken into account in prescribing this medication?
- Is the patient taking a quantity of medication that is consistent with the Doctor's directions on the prescription?

When you use your card

When you use your Empire Plan Benefit Card at a Network Pharmacy or a Mail Service Pharmacy or the Designated Specialty Pharmacy and the Pharmacist enters the information into the computer, the computer system will review your recent Empire Plan Prescription Drug Program medication history. If a possible problem is found, a warning message will be flashed to your Pharmacist.

The Pharmacist may talk with you and your Doctor. Once any issues are resolved, the appropriate medication can be dispensed.

Safety

In addition, a "behind the scenes" safety review is conducted to identify any potential drug therapy related problems. If a potential problem is detected, the information is reviewed by a clinical Pharmacist who notifies your Doctor of

the possible risks. If two prescribing Doctors are involved, both will be notified of the potential problem.

If, as the result of DUR, it is determined that a member may be using prescription medications in a harmful or abusive manner or with harmful frequency, the Plan reserves the right to limit an enrollee to the use of a single network pharmacy plus the Mail Service Pharmacy or the Designated Specialty Pharmacy.

This process helps your Doctor make more informed decisions about your prescription drugs.

Refill Too Soon

A key component of the DUR safety process implemented for this Program is the application of the "refill too soon" (RTS) edit for all claims submitted under the Program. The RTS program ensures that The Empire Plan Prescription Drug Program provides safety and utilization review across all supply chains; Network Pharmacy claims, Mail Service Pharmacy or the Designated Specialty Pharmacy claims and Non-Network Pharmacy claims processed for an individual enrollee. Upon processing of an incoming claim, the previous 180 days of an enrollee's prescription drug claim history are reviewed by the systematic RTS criteria. The RTS edit will cause the claim to reject if the enrollee has consumed (based on days supply) less than 75 percent of their medication on a cumulative basis over the past 180 days. When a claim is rejected, the Pharmacist is sent a message indicating the next refill date for the enrollee. Certain drugs that have quantity level limits, such as erectile dysfunction drugs, have more restrictive RTS limits to comply with the quantity allowed per days supply. See Supply and Coverage Limits on page 289 for additional information. The RTS will also take into account the cumulative days supply on hand.

Confidential Service

Confidentiality is key. You can be assured that these reviews are confidential and that pertinent information is shared only with your Pharmacist and Doctor or as permitted or required by law.

Education is the Right Prescription

For patients

It's important that you understand the drugs being prescribed for you – what they will do and how they should be taken. To help you with that understanding, The Empire Plan Prescription Drug Program has a patient education program.

For doctors

To help your Doctor keep up to date on the most current information on prescription drugs, The Empire Plan has a doctor education program.

2010 Empire Plan Copayments for Contract Affected Employees of New York State in NYSCOPBA (except employees in lifeguard titles)

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 $20

Office Surgery $20

(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 $20

(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 $20

Adult Immunizations $20

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 $20

Urgent Care Center $20

Contraceptive Drugs and Devices when
dispensed in a doctor's office $20
(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 $20

Radiology; Diagnostic Laboratory Tests $20

(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*

(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 $35*

Diagnostic Laboratory Tests $35*

Diagnostic Radiology (including
mammography, according
to guidelines) $35*

Administration of Desferal for
Cooley's Anemia $35*

Physical Therapy (following related surgery
or hospitalization) $20

Chemotherapy,
Radiation Therapy, Dialysis .....No copayment

Pre-Admission Testing/Pre-Surgical
Testing prior to inpatient admission ....No copayment

*__Only one__ copayment 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 $20

Visit to Mental Health Professional $20

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 or the Designated Specialty Pharmacy

Level 1 or Generic Drug.....$5

Level 2 or Preferred Brand-Name Drug $15

Level 3 or Non-Preferred Brand-Name Drug.....$40**

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

Level 1 or Generic Drug.....$10

Level 2 or Preferred Brand-Name Drug $30

Level 3 or Non-Preferred Brand-Name Drug.....$70**

31- to 90-day supply through the Mail Service Pharmacy or the Designated Specialty Pharmacy

Level 1 or Generic Drug.....$5

Level 2 or Preferred Brand-Name Drug $20

Level 3 or 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.