

# JANUARY 1, 2013 AMENDMENTS



## **NYSHIP General Information Book and Empire Plan Certificate Amendments**

### **Agency Police Services Unit**

For Employees of the State of New York in the **Agency Police Services Unit (APSU)** who are represented by the **Police Benevolent Association of New York State (PBANYS)**, their enrolled Dependents, COBRA Enrollees with their benefits and Young Adult Option Enrollees

**Keep these amendments with your July 1, 2003 Council 82 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.

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



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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.

Amendments on the following pages are effective on January 1, 2012 unless individually dated. Where this document differs from your July 1, 2003 *NYSHIP General Information Book* and *Empire Plan Certificate* and later *Empire Plan Reports* and *Certificate Amendments*, this is the controlling document.

## EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM AMENDMENTS

*Substitute "combined annual deductible" for "basic medical annual deductible" and "penalty" for "hospital deductible" wherever they appear under "The Empire Plan Benefits Management Program" section on pages 43-47 of your Empire Plan Certificate.*

*Substitute the following for "You must call the Empire Plan toll-free at 1-877-7-NYSHIP (1-877-769-7447) and Choose UnitedHealthcare:" under "The Empire Plan Benefits Management Program" section on page 43 of your Empire Plan Certificate.*

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

**Effective April 1, 2012**, before having an elective (nonemergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) 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" in "The Empire Plan Benefits Management Program: Benefits and Your Responsibilities" in "The Empire Plan Benefits Management Program" section on page 46 of your Empire Plan Certificate.*

4. **Prospective Procedure Review: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) or Nuclear Medicine test.**

**Effective April 1, 2012**, 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 (nonemergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) 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 these 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 the second paragraph of “5. Medical Case Management” in “The Empire Plan Benefits Management Program: Benefits and Your Responsibilities” in “The Empire Plan Benefits Management Program” section on page 47 of your Empire Plan Certificate.*

Some catastrophic or complex cases, such as head injuries, neonatal (newborn) complications or certain chronic conditions, may require extended care. If you or a member of your family requires this type of care, you may be faced with many decisions about treatment plans and facilities. The Benefits Management Program can provide information that may help you make the choices that are best for you.

*Substitute the following for the heading and first sentence of “Outpatient MRI” in “The Empire Plan Benefits Management Program” section on page 51 of your Empire Plan Certificate.*

**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 “MRI” wherever it appears under “The Empire Plan Benefits Management Program” and in the Empire BlueCross BlueShield and UnitedHealthcare Certificates.*

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

# EMPIRE PLAN HOSPITAL PROGRAM: CERTIFICATE AMENDMENTS

## Network and Non-Network Benefits (Effective April 1, 2012)

*Substitute the following for items 1. and 2. in the "Network and Non-Network Benefits" section on page 52 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

1. Network benefits: When you use a network hospital, skilled nursing facility or hospice care facility, inpatient and outpatient covered services are paid in full except for:
  - A. Any applicable hospital outpatient copayments. Hospital emergency room visits are subject to a \$70 copayment, outpatient surgical expenses are subject to a \$60 copayment, diagnostic outpatient services (diagnostic radiology, including mammography; diagnostic laboratory tests and administration of Desferal for Cooley's Anemia) are subject to a \$40 copayment and physical therapy services are subject to a \$20 copayment; and
  - B. Any penalty amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.
2. Non-network benefits: When you use a non-network hospital, skilled nursing facility or hospice care facility, you are responsible for a larger share of the cost of Covered Services, unless the criteria listed in section C apply. You are responsible for:
  - A. 10 percent of the billed charges for inpatient hospital, skilled nursing facility or hospice care facility services up to the combined annual coinsurance maximum;
  - B. 10 percent of the billed charges or a \$75 copayment for hospital outpatient services, whichever is greater, up to the combined annual coinsurance maximum; and
  - C. Any penalty amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.

**The covered percentage becomes 100 percent of the billed charges for inpatient services only once the combined annual coinsurance maximum is met.**

**Effective April 1, 2012**, the combined annual coinsurance maximum is \$3,000 for the enrollee, \$3,000 for the enrolled spouse/domestic partner and \$3,000 for all dependent children combined.

Coinsurance amounts incurred under the Basic Medical, Hospital and Mental Health and Substance Abuse (MHSA) Programs are applied to the combined annual coinsurance maximum. Copayments for Participating Provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum.

Non-network coinsurance and copayment amounts apply in addition to any amounts that are your responsibility because of your failure to meet the requirements of the Benefits Management Program.

## Outpatient Hospital Care

*Substitute the following for the second sentence of the first paragraph of the section entitled "Outpatient Hospital Care" on page 53 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

This coverage also applies to services provided at a hospital extension clinic (a remote location including outpatient surgical locations and urgent care centers) owned and operated by the hospital.

*Substitute the following for "Copayment for emergency care" in the "Outpatient Hospital Care" section on page 55 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

### Copayment for emergency care

You must pay the first \$70 in charges (copayment) for emergency care in a hospital emergency room. See page 53, "Outpatient Hospital Care" for emergency care. Hospitals may require payment of this charge at the time of service.

The \$70 emergency room copayment covers use of the facility for emergency care and services of the emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and pathology services. Refer to your UnitedHealthcare Certificate, page 81, "What is Covered Under the Basic Medical Program (nonparticipating providers)", if you receive bills for hospital emergency room service from these providers.

You will not have to pay this \$70 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

*Substitute the following for the first three paragraphs of "Copayment for outpatient hospital services" in the "Outpatient Hospital Care" section on page 55 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

### **Copayments for outpatient hospital services**

Except as noted, you must pay the first \$60 (copayment) for outpatient surgical expenses and the first \$40 (copayment) for one or more of the diagnostic outpatient services, as follows, for each visit to a network facility or the greater of 10 percent of charges or \$75 at a non-network facility. Hospitals may require payment of this charge at the time of service.

Hospital outpatient services include:

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

One copayment (\$60 if surgery is included or \$40 if it is not) covers the outpatient facility and will apply for all covered hospital outpatient services. You will not have to pay the copayments for outpatient surgical expenses or hospital outpatient expenses if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you at that time as an inpatient.

*Add the following as the next to last paragraph under "Copayment for outpatient hospital services" in the "Outpatient Hospital Care" section on page 55 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

**Effective October 1, 2011** – There is no copayment for certain preventive services received at a network hospital as required under the Patient Protection and Affordable Care Act, such as an annual mammogram for covered females age 40 and older and colonoscopies for covered enrollees age 50 to 75.

**Effective January 1, 2013** – There is no copayment for covered birth control surgeries provided at a network facility.

### **Skilled Nursing Facility Care**

*Substitute the following for the first paragraph and "1. Conditions for skilled nursing facility care" under "Skilled Nursing Facility Care" on page 55 of the Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

Benefits are subject to the requirements of The Empire Plan's Benefits Management Program. The Empire Plan does not provide Skilled Nursing Facility benefits, even for short-term rehabilitative care, for Retirees, Vestees and Dependent Survivors or their Dependents who are eligible for primary benefits from Medicare.

1. **Conditions for skilled nursing facility care.** Empire BlueCross BlueShield will pay for your care in a skilled nursing facility described in item 2. 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 preadmission 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 your *NYSHIP General Information Book* for information on primary coverage under Medicare.

## Transplants

*Substitute the following for "Types of Transplants" in the "Centers of Excellence for Transplants Program" section on page 56 of your Empire BlueCross BlueShield Certificate.*

### Types of Transplants

The benefits under the Centers of Excellence for Transplants Program are available for the following types of transplants:

- Bone Marrow
- Cord Blood Stem Cell
- Heart
- Heart-Lung
- Kidney
- Liver
- Lung
- Pancreas
- Pancreas after Kidney
- Peripheral Stem Cell
- Simultaneous Kidney/Pancreas

This is the list of procedures available at the date of printing. As additional Centers of Excellence are added to the Transplant Program, this list may change. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program for the most up-to-date information on the types of transplants covered.

*Delete the last paragraph under "What is covered" in the "Centers of Excellence for Transplants Program" section on page 57 of your Empire BlueCross BlueShield Certificate. The travel process described in that paragraph has been moved to a new section.*

## Infertility Benefits

*Substitute the following for the last bullet in the sixth paragraph of "What is covered" in the "Infertility Benefits" section on page 58 of your Empire BlueCross BlueShield Certificate.*

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

## Travel Allowance

*Add the following after the "Infertility Benefits" section on page 59 of your Empire BlueCross BlueShield Certificate.*

### Centers of Excellence Travel Allowance

When you enroll in the Centers of Excellence for Transplants Program or are preauthorized for Infertility Benefits, you will not have to make any copayments for services performed at a qualified Center of Excellence. A travel, lodging and meal expenses benefit is available to you for travel within the United States. 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. If the patient is a minor child, the benefit will include coverage for up to two travel companions. 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. The Travel Allowance will be applied toward the \$50,000 maximum lifetime benefit for Infertility Benefits.

## Limitations and Exclusions

Add the following as item 16. under "Limitations and Exclusions" in the "Empire BlueCross BlueShield General Provisions" section on page 62 of your Empire BlueCross BlueShield Certificate.

16. **Preventable Adverse Events and Conditions.** Empire BlueCross BlueShield will not pay for services related to events or errors in medical care that are clearly identifiable, preventable and serious in their consequences. The enrollee will **not** be responsible for these expenses.

- Preventable adverse events include foreign object retained after surgery, surgery performed on the wrong patient, wrong surgical procedure performed or surgery performed on the wrong body part.
- Preventable conditions include stage III and IV pressure ulcers, catheter-associated urinary tract infections, surgical site infections, manifestations of poor glycemic control, deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

## Coordination of Benefits

Add the following as the last paragraph of the "Coordination of Benefits (COB)" section on page 64 of your Empire BlueCross BlueShield 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.

## Medicare

Substitute "domestic partner or same-sex spouse" for "domestic partner" wherever it appears in the "If You Qualify for Medicare" section on pages 64-66 of your Empire BlueCross BlueShield Certificate.

## Benefits After Termination

Substitute the following for the first paragraph of "3. Benefits after termination" in the "Termination of Your Empire BlueCross BlueShield Coverage" section on page 66 of your Empire BlueCross BlueShield Certificate.

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.

## Recovery of Overpayments and Subrogation

Substitute the following for "3. Recovery of overpayments" in the "Miscellaneous Provisions" section on page 67 of your Empire BlueCross BlueShield Certificate.

3. **Recovery of overpayments.** 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.

## Utilization Review Guidelines

*Add the following immediately before the "Appeals" section on page 69 of your Empire BlueCross BlueShield Certificate.*

If we have all the information necessary to make a determination regarding a preadmission or prospective procedure review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to preadmission or prospective procedure review of urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

**Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified previously for preadmission or prospective procedure review of urgent claims.

If we have already approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

**Retrospective Reviews.** If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

**Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not medically necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our determination, date of service, provider name and claim amount (if applicable). The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

## Appeals

*Substitute the following for the "Filing An Appeal" section on pages 69-71 of your Empire BlueCross BlueShield Certificate.*

You or another person acting on your behalf may submit an appeal. If a post service claim (a claim for benefits payment after medical care has been received) or a preservice request for benefits (including a request for benefits that requires notification, precertification or benefit confirmation prior to receiving medical care) is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal by writing to:

New York State Service Center  
Medical Management Appeals Department  
Mail Drop R 60 PO Box 11825  
Albany, NY 12211

Or, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program, Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

### Appeal process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with Empire BlueCross BlueShield's Medical Director or a health care professional with appropriate expertise who is credentialed by the national accrediting body appropriate to the profession in that field, and who was not involved in the prior determination. Empire BlueCross BlueShield may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent hospital claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefit. In addition, if any new or additional evidence is relied upon or generated by Empire BlueCross BlueShield during the determination of the appeal, it will be provided to you free of charge and sufficiently in advance of the due date of the decision of the appeal.

### Level 1 Appeals

A request for review must be directed to Empire BlueCross BlueShield within 180 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, you should state the reason why you believe the claim determination or precertification improperly reduced or denied your benefits. Also, submit any data or comments to support the appeal of the original determination as well as any data or information requested by Empire BlueCross BlueShield. A written acknowledgment of your appeal will be sent to you within 15 days after it is received.

For a first level appeal of a post service claim, a review of the appeal will be done and within 30 days of your request, Empire BlueCross BlueShield will provide you with a written decision.

For a first level appeal of a preservice request for benefits, a review of the appeal will be done and within 15 days of your request, Empire BlueCross BlueShield will provide you with a written decision.

If the determination is upheld, Empire BlueCross BlueShield's written response will cite the specific Plan provision(s) upon which the denial is based and will include both of the following:

- Detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.
- Notification of your right to a further review.

### Level 2 Appeals

If, as a result of the Level 1 review, the original determination of benefits is upheld by Empire BlueCross BlueShield, in whole or in part, you can request a Level 2 review. This request should be directed either in writing or by telephone to Empire BlueCross BlueShield within 60 days after you receive notice of the Level 1

appeal determination. When requesting the Level 2 review, you should state the reasons you believe the benefit reduction or denial was improperly upheld and include any information requested by Empire BlueCross BlueShield along with any additional data, questions or comments deemed appropriate.

For a second level appeal of a post service claim, a review of the appeal will be done and within 30 days of your request, Empire BlueCross BlueShield will provide you with a written decision.

For a second level appeal of a preservice request for benefits, a review of the appeal will be done and within 15 days of your request, Empire BlueCross BlueShield will provide you with a written decision.

If the determination is upheld, Empire BlueCross BlueShield's written response will cite the specific Plan provision(s) upon which the denial is based and will provide detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.

**Appeals involving urgent situations:** If an appeal involves a situation in which a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain, the appeal will be resolved and you will be notified of the determination in no more than 72 hours following receipt of the appeal. Notice of the determination will be made directly to the person filing the appeal (you or the person acting on your behalf).

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

## **External Appeals**

### **Your right to an External Appeal**

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Empire BlueCross BlueShield has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, 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 Financial Services 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 previously and if any new or additional information regarding the service or procedure was presented for consideration, Empire BlueCross BlueShield must have upheld the denial or you and Empire BlueCross BlueShield 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 previously and if any new or additional information regarding the service or procedure was presented for consideration, Empire BlueCross BlueShield must have upheld the denial or you and Empire BlueCross BlueShield must agree in writing to waive any internal appeal.

Your attending physician must certify that you have a condition/disease whereby 1) standard health services or procedures have been ineffective or would be medically inappropriate, or 2) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or 3) for which there exists a clinical trial or rare disease treatment.

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 Financial Services to obtain current information about what documents will be considered acceptable); 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 condition or disease.

**Your right to appeal that a service should be covered since it is considered a rare disease** is defined as a condition:

- That is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or affects fewer than 200,000 United States residents per year; and
- For which there are no standard health services or procedures covered by the health care plan that are more clinically beneficial than the requested service or treatment.

As part of the external appeal process for rare diseases, a physician other than the member's treating physician, must certify in writing that the condition is a rare disease. The certifying physician must be a licensed, board-certified or board-eligible physician specializing in the appropriate area of practice to treat the rare disease. The physician's certification must provide either that the rare disease:

- Is or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
- Affects fewer than 200,000 United States residents per year.

The certification is to rely on medical and scientific evidence to support the requested service or procedure (if such evidence exists) and must include a statement that, based on the physician's credible experience, there is no standard treatment that will be more clinically beneficial to the member. The statement must also indicate that the requested service or procedure is likely to benefit the member in the treatment of their rare disease and that the benefit outweighs the risks of the service or procedure.

**The External Appeal process:** If, through the internal appeal process described previously, 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 four months from receipt of such notice to file a written request for an external appeal. If you and Empire BlueCross BlueShield have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. Empire BlueCross BlueShield will provide an external appeal application with the final adverse determination issued through Empire BlueCross BlueShield's internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services 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 Empire BlueCross BlueShield based its denial, the External Appeal Agent will share this information

with Empire BlueCross BlueShield in order for it to exercise its right to reconsider its decision. If Empire BlueCross BlueShield chooses to exercise this right, Empire BlueCross BlueShield will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), Empire BlueCross BlueShield 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 Empire BlueCross BlueShield. 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 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Empire BlueCross BlueShield 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 Empire BlueCross BlueShield's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, Empire BlueCross BlueShield 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, Empire BlueCross BlueShield will only cover the costs of services required to provide treatment to you according to the design of the trial. Empire BlueCross BlueShield shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth-care services, the costs of managing research, or costs that would not be covered under the Policy for nonexperimental or noninvestigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Empire BlueCross BlueShield. The External Appeal Agent's decision is admissible in any court proceeding.

You will be charged a fee of \$25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. Empire BlueCross BlueShield 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 Financial Services. 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.

### **Four-Month External Appeal deadline**

Under New York State law, your completed request for external appeal must be received by the Department of Financial Services within four months (with an additional eight days allowed for mailing) of the date of the Final Notice of Adverse Determination of the first level appeal or the date upon which you receive a written waiver of any internal appeal. Empire BlueCross BlueShield has no authority to grant an extension of this deadline.

# EMPIRE PLAN MEDICAL/SURGICAL PROGRAM: CERTIFICATE AMENDMENTS

Substitute "\$20 copayment" for "\$15 copayment" or "\$18 copayment" wherever the \$15 or \$18 appears in your UnitedHealthcare Certificate.

Substitute "combined annual deductible" for "annual Basic Medical deductible", "Basic Medical annual deductible" or "Basic Medical Program annual deductible" wherever the terms appear in your UnitedHealthcare Certificate.

## Conversion of The Empire Plan Medical/Surgical Program to Self-Insured

Delete the Certificate of Insurance signature page on page 73 of your UnitedHealthcare Certificate. **Note:** Effective January 1, 2013, The Empire Plan Medical/Surgical Program, which provides coverage for certain medical and surgical services, was converted from fully insured to self-insured under a self-insured administrative services agreement between the New York State Department of Civil Service (DCS) and UnitedHealthcare Insurance Company of New York (UnitedHealthcare). The Medical/Surgical Program is self-insured by DCS and UnitedHealthcare is the administrative services provider.

## Plan overview

Substitute the following for the second paragraph under the heading "Basic Medical Program (A Nonparticipating Provider)" on page 74 of your UnitedHealthcare Certificate.

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.

## Outpatient Tests

Substitute the following for "Outpatient MRI" in the "Plan Overview" section on page 75 of your UnitedHealthcare Certificate.

### 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 86. 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.

## Meaning of Terms Used

Substitute the following for item A. under "Meaning of Terms Used" on page 76 of your UnitedHealthcare Certificate.

- A. **This Plan** means the medical expense coverage, described in this plan document (previously provided under Group Policy Nos. 30500-G and 30501-G as of December 31, 2012) and any subsequent amendments, which is self-insured by the New York State Department of Civil Service and for which UnitedHealthcare Insurance Company of New York is the administrative services provider.

Substitute the following for item C. of "Meaning of Terms Used" on page 76 of your UnitedHealthcare Certificate.

- C. **Effective April 1, 2012. Provider** means any Audiologist, Certified Nurse Midwife, Chiropractor, Convenience Care Clinic, Dentist, Doctor, Home Health Care Agency, Laboratory, Licensed Nurse Practitioner, Nurse, Occupational Therapist, Optometrist, Outpatient Surgical Location, Pathologist, Physical Therapist, Podiatrist, Speech Therapist, Speech-Language Pathologist, Visiting Nurse Service. Also, facilities legally licensed to perform a covered medical service (e.g., Dialysis Centers).

*Substitute the following for the first two lines of item "N. Medically Necessary or Medical Necessity" in the "Meanings of Terms Used" section on page 77 of your UnitedHealthcare Certificate.*

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

*Substitute the following for item "O. Covered Medical Expenses" in the "Meanings of Terms Used" section on pages 77 and 78 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 as follows, 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. 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" in the "Meanings of Terms Used" section on page 78 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 Q. under "Meaning of Terms Used" on page 78 of your UnitedHealthcare Certificate.*

- Q. **Combined annual deductible** means the amount you must pay in total, each calendar year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program expenses and/or non-network Mental Health and Substance Abuse Program expenses before benefits will be paid under these components of the Plan.

**Effective April 1, 2012**, The Empire Plan combined annual deductible is \$1,000 for the enrollee, \$1,000 for the enrolled spouse/domestic partner and \$1,000 for all dependent children combined. The combined annual deductible must be met before your claims can be reimbursed.

There is a separate deductible of \$250 for the enrollee, \$250 for the enrolled spouse/domestic partner and \$250 for all dependent children combined for non-network physical medicine office visits under the Managed Physical Medicine Program.

*Substitute the following for item "S. Coinsurance" in the "Meanings of Terms Used" section on page 78 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 items T. 2. a. and T. 2. b. of "T. "Covered Percentage" under "Meaning of Terms Used" on pages 78 and 79 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 under "Prospective Procedure Review: MRI"; under "Home Care Advocacy Program"; under "Coinsurance and \$1,500 Annual Maximum Apply" for the Managed Physical Medicine Program and under "Infertility Centers of Excellence"; and
  - b. The covered percentage becomes 100 percent of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once the combined annual coinsurance maximum is met.

**Effective April 1, 2012**, the combined annual coinsurance maximum is \$3,000 for the enrollee, \$3,000 for the enrolled spouse/domestic partner and \$3,000 for all dependent children combined.

Coinsurance amounts incurred under the Basic Medical, Hospital and Mental Health and Substance Abuse (MHSA) Programs are applied to the combined annual coinsurance maximum. Copayments for Participating Provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum.

**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 nonparticipating providers counts toward your coinsurance maximum. Expenses under the Home Care Advocacy Program, Managed Physical Medicine Program and the Benefits Management Program do not count toward the coinsurance maximum, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program.

Once the combined annual 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.

Substitute the following for item W. in the "Meanings of Terms Used" section on page 78 of your UnitedHealthcare Certificate.

- W. The **Annual Maximum** for the Basic Medical portion of this Plan is unlimited.

Add the following as the last items under "Meaning of Terms Used" on page 79 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 Thomson Reuters. The Pharmaceutical Product pricing information is updated annually on October 1<sup>st</sup>. 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 nonparticipating provider that exceeds the Scheduled Pharmaceutical Amount in addition to the combined 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.

AF. **Effective April 1, 2012. A Convenience Care Clinic** is a health care clinic located in a fixed location in a retail store, supermarket or pharmacy that treats uncomplicated minor illnesses and provides preventive health care services. It is staffed by medical professionals that include physicians, licensed nurse practitioners, physician assistants and nurses and is designed to provide fast, appointment-free health care services. Only services received at a participating Convenience Care Clinic are covered; services received at a nonparticipating Convenience Care Clinic are not covered.

## Participating Provider Program

*Substitute the following for "Your out-of-pocket expenses are lower when you choose participating providers" in the "Participating Provider Program" section on page 80 of your UnitedHealthcare Certificate.*

### **Your out-of-pocket expenses are lower when you choose participating providers**

**If the services you receive are for other than preventive care as required by the Patient Protection and Affordable Care Act (PPACA), you pay only your \$20 copayment(s) for office visits, home visits, surgical procedures performed during an office visit, radiology services, diagnostic laboratory services and visits to a cardiac rehabilitation center, urgent care center or convenience care clinic when they are covered under the Participating Provider Program.** You pay only your \$30 copayment for facility charges, including anesthesiology, at a **participating outpatient surgical location**. There is no cost to you for some services covered under the Participating Provider Program.

*Substitute the following for the second paragraph of "Finding Participating Providers" in the "Participating Provider Program" section on page 80 of your UnitedHealthcare Certificate.*

The Directory also lists physicians in the following areas who are in the UnitedHealthcare Options Preferred Provider Organization (PPO) network and have agreed to participate in The Empire Plan: Arizona; Connecticut; Florida; Maryland; New Jersey; North Carolina; Pennsylvania; South Carolina; Virginia; Washington, D.C.; West Virginia and the greater Chicago area. Ask physicians in these areas if they are in the UnitedHealthcare Options PPO network and tell them you are covered by The Empire Plan. In all other states including New York, and for providers other than physicians in these areas, ask if the provider participates in The Empire Plan.

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

### **Guaranteed Access**

The Empire Plan will guarantee access to primary care physicians and specialists (listed as follows) in New York or in the counties of Fairfield and Litchfield in Connecticut; Berkshire in Massachusetts; Bergen, Hudson, Middlesex, Passaic, Sussex and Union in New Jersey; Bradford, Erie, McKean, Pike, Potter, Susquehanna, Tioga, Warren and Wayne in Pennsylvania; and Addison, Bennington, Chittenden, Grand Isle and Rutland in Vermont, when there is not an Empire Plan participating provider within a reasonable distance from an enrollee's residence (see chart that follows).

To receive network benefits, enrollees must contact the Medical Program at **1-877-7-NYSHIP (1-877-769-7447)** prior to receiving services and use one of the providers approved by the Program. You will be responsible for contacting the provider to arrange care. Appointments are subject to provider's availability and the Program does not guarantee that a provider will be available in a specified time period. Guaranteed access applies when The Empire Plan is your primary health insurance coverage (pays benefits first, before any other group plan or Medicare), the enrollee lives in New York State or counties listed in the previous paragraph in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont and there is not an Empire Plan participating provider within a reasonable distance from the enrollee's residence.

Reasonable distance from the enrollee's residence is defined by the following mileage standards:

**Primary Care**

Urban: 8 miles  
Suburban: 15 miles  
Rural: 25 miles

**Specialist**

Urban: 15 miles  
Suburban: 25 miles  
Rural: 50 miles

Within these mileage standards, network benefits are guaranteed for the following primary care physicians and core specialties:

**Primary Care Physicians**

Family Practice  
General Practice  
Internal Medicine  
Pediatrics  
Obstetrics/Gynecology

**Specialties**

Allergy  
Anesthesia  
Cardiology  
Dermatology  
Emergency Medicine  
Gastroenterology  
General Surgery  
Hematology/Oncology  
Neurology  
Ophthalmology  
Orthopedic Surgery  
Otolaryngology  
Pulmonary Medicine  
Radiology  
Rheumatology  
Urology

*Substitute the following for the first paragraph of item "A. Office and Home Visits" in the "What is covered under the Participating Provider Program" section on page 80 of your UnitedHealthcare Certificate.*

**Office and Home Visits** – You are covered for office visits and home visits for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-child care. General medical care includes routine and preventive pediatric care and routine and preventive adult care including gynecologic exams.

In addition to the copayment for the office or home visit, if any, you pay the following copayment(s) for diagnostic tests and radiology:

- You pay one copayment for labs or other diagnostic tests **drawn and processed** at a participating physician's office. If the physician's office collects the specimen and sends it to an outside participating laboratory for testing, you pay one additional copayment for the outside laboratory services.
- You pay one copayment for radiology performed at a participating provider's office. If the radiology test is sent to an outside participating physician to be evaluated, you pay one additional copayment for the outside physician services.

A maximum of two copayments can be charged per day for *each* participating provider if you receive multiple services that are subject to a copayment.

If your participating physician uses a nonparticipating provider for laboratory testing or interpretation of radiology, that service is covered under Basic Medical Program benefits, subject to deductible and coinsurance.

The cost of oral and injectable substances for routine preventive pediatric immunizations is covered. The meningitis immunization is also a covered expense for dependents up to age 26. Some immunizations for adults and certain at-risk populations also are covered (see next page for a list).

The cost of FDA-approved contraceptive methods for women, including sterilization, that require physician intervention are covered and are not subject to a copayment.

*Substitute the following for item "F. Adult Immunizations" in the "Participating Provider Program" section on page 81 of your UnitedHealthcare Certificate.*

- F. Adult Immunizations** – Paid-in-full benefit for covered adult immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention when received from a participating provider, including influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chickenpox), tetanus immunizations, Human Papillomavirus (HPV) immunizations (covered for enrollees and dependents age 19 through 26), meningitis immunizations and Herpes Zoster (Shingles) immunizations (covered for enrollees and dependents age 60 or older; enrollees and dependents age 55 through 59 are subject to a \$20 copayment).

The copayment also covers the cost of oral and injectable substances received from a participating provider.

*Add the following as the second paragraph of item "G. Routine Mammograms" under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 81 of your UnitedHealthcare Certificate.*

**Effective January 1, 2013**, there is no copayment for an annual mammogram for covered females age 40 and older provided under the Patient Protection and Affordable Care Act.

*Substitute the following for item "H. Ambulatory Surgical Center" under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 81 of your UnitedHealthcare Certificate.*

- H. Effective April 1, 2012. 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 items S, T, and U, under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 82 of your UnitedHealthcare Certificate.*

- 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.
- T. Contraceptive Drugs and Devices** – **Effective January 1, 2013**, you are covered in full for an office visit, when the visit is solely for the purpose of obtaining such drug or device, including contraceptive drugs and devices dispensed by the provider.
- U. Prostheses and Orthotic Devices** – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs. There is no copayment for the prosthesis and/or orthotic device when you use a participating provider. Replacements, when functionally necessary, are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot, is covered only when it is medically necessary and custom-made.

*Add the following as the last items under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 82 of your UnitedHealthcare Certificate.*

- V. Mastectomy Bras** – Mastectomy bras, including replacements when functionally necessary, are covered when prescribed by a physician. There is no copayment when you use a participating provider.

- W. **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.
- X. **Dental Care** – You are covered for dental services including Pharmaceutical Products and appliances dispensed by a provider:
- For the correction of damage caused by an accident, provided the services, supplies or Pharmaceutical Products are received within 12 months of the trauma and while you are covered under this Plan.
  - For the correction of damage caused by a medical illness, congenital disease or anomaly for which you are eligible for benefits under this Plan.
  - For charges incurred for temporomandibular joint syndrome (TMJ) for the following conditions that are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by X-ray: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections and traumatic injuries. For TMJ, covered services, supplies or Pharmaceutical Products include: diagnostic exams, X-rays, models and testing, injections of medications and trigger point injections.
- Y. **Breast Pumps – Effective January 1, 2013**, you are covered for purchase of a double-electric breast pump or rental of a hospital-grade breast pump following the birth of your child. This is a network benefit only; you must utilize a UnitedHealthcare national provider.

## Basic Medical Program

*Substitute the following for items A., B. and C. under “You must meet a deductible and pay 20% coinsurance...” in the “Basic Medical Program” section on page 83 of your UnitedHealthcare Certificate.*

### A. Annual Deductible

See page 313 of your January 2013 *UnitedHealthcare Certificate Amendments* for the combined annual deductible for covered services supplied by nonparticipating providers. You must meet the combined annual deductible before your Basic Medical claims can be reimbursed.

### 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 as follows, 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.

*Delete item “B. Non-Network Hospital...” under “What is covered under the Basic Medical Program (nonparticipating providers)” in the “Basic Medical Program” section on page 84 of your UnitedHealthcare Certificate, and change the remaining item letters accordingly. The process and spending described in that paragraph no longer apply.*

*Substitute the following for the second paragraph of item "C. Hospital Emergency Room" under "What is covered under the Basic Medical Program (nonparticipating providers)" on page 84 of your UnitedHealthcare Certificate. Services provided by other specialty physicians in a hospital Emergency Room are considered under the Participating Provider Program if the physician participates. If the Emergency Services are provided by a nonparticipating provider, the charges will be considered under the Basic Medical Program subject to deductible but not coinsurance.*

*Substitute the following for items G. and H. under "What is covered under the Basic Medical Program (nonparticipating providers)" on page 84 of your UnitedHealthcare Certificate.*

- G. Routine Health Exams for Active Employees** – Routine health exams are covered for you, the active employee, if you are age 50 or over and for your spouse/domestic partner age 50 or older. These benefits are not subject to deductible or coinsurance.
- H. Routine Newborn Child Care** – Doctor's services for routine care of a newborn child are covered. These benefits are not subject to deductible or coinsurance.

*Add the following as the second paragraph of item "J. Mammograms as Part of Routine Preventive Care" under "What is covered under the Basic Medical Program (nonparticipating providers)" in the "Basic Medical Program" section on page 84 of your UnitedHealthcare Certificate.*

New York State Law provides for an annual mammogram for covered females age 40 and older. *This benefit is not subject to deductible or coinsurance.*

*Add the following as item "O. Surgery" and change the letters of subsequent items accordingly in the "What is covered under the Basic Medical Program (nonparticipating providers)" in the "Basic Medical Program" section on page 85 of your UnitedHealthcare Certificate.*

- O. Surgery** – You are covered for the services of a doctor for surgery, including post-operative care, under the Basic Medical Program when not covered elsewhere by the Plan.

Multiple surgical procedures performed during the same operative session may be subject to a reduction in reimbursement. Multiple surgical procedures shall be reimbursed in an amount not less than the reasonable and customary charge for the most expensive procedure performed. Less expensive procedures shall be reimbursed in an amount at least equal to 50 percent of the reasonable and customary charge for these secondary procedures.

When you use a participating provider, you are responsible only for any applicable copayment(s).

*Substitute the following for item "P. Prosthetics" under "What is covered under the Basic Medical Program (nonparticipating providers)" in the "Basic Medical Program" section on page 85 of your UnitedHealthcare Certificate.*

- P. Prostheses and Orthotic Devices** – One prosthesis and/or orthopedic appliance commonly known as an orthotic device, per affected body part meeting an individual's functional needs is covered. Replacements when functionally necessary are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot, is covered under the Basic Medical Program only when it is medically necessary and custom-made.

*Add the following as the last items under "What is covered under the Basic Medical Program (nonparticipating providers)" on page 86 of your UnitedHealthcare Certificate.*

- AB. Prosthetic Wigs – Effective April 1, 2012**, 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.

- AC. **Diabetes Education Centers – Effective April 1, 2012**, if you have a diagnosis of diabetes you are covered for medically necessary visits for self-management.
- AD. **Dental Care** – You are covered for dental services including Pharmaceutical Products and appliances dispensed by a provider:
- For the correction of damage caused by an accident, provided the services, supplies or Pharmaceutical Products are received within 12 months of the trauma and while you are covered under this Plan.
  - For the correction of damage caused by a medical illness, congenital disease or anomaly for which you are eligible for benefits under this Plan.
  - For charges incurred for temporomandibular joint syndrome (TMJ) for the following conditions that are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by X-ray: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections and traumatic injuries. For TMJ, covered services, supplies or Pharmaceutical Products include: diagnostic exams, X-rays, models and testing, injections of medications and trigger point injections.

## Benefits Management

*Substitute the following for “Pre-Admission Certification: Hospital” in the “Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review” section on page 86 of your UnitedHealthcare Certificate.*

### **Preadmission Certification: Hospital**

If you do not comply with Preadmission Certification requirements for hospital admission, a \$200 penalty will be applied. You will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

*Substitute the following for “Prospective Procedure Review: MRI” in the “Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review” section on page 86 of your UnitedHealthcare Certificate.*

### **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 (nonemergency) 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 (nonemergency) 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 (nonemergency) 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.

## Home Care Advocacy Program (HCAP)

*Add the following as the second paragraph under “Network coverage: Paid-in-full benefit” in the “Home Care Advocacy Program” section on page 87 of your UnitedHealthcare Certificate.*

If Medicare is your primary carrier and you receive items or services from a Medicare-approved supplier, The Empire Plan will pay the balance after Medicare at 100 percent.

Add the following as the fourth paragraph under "Network coverage: Paid-in-full benefit" in the "Home Care Advocacy Program" section on page 87 of your UnitedHealthcare Certificate.

### **Important Notes:**

- If Medicare is your primary coverage, you must use a Medicare contract provider.
- The Medicare Durable Medical Equipment and Prosthetic and Orthotics Supplies Competitive Bidding Program: If you are a Medicare prime member living in a competitive bidding area and require mail order diabetic testing supplies, or any other items covered under the program, you must use a Medicare contract supplier. For information regarding the Competitive Bidding Program or to locate a Medicare contract supplier, please contact Medicare by calling 1-800-MEDICARE (1-800-633-4227). If you need additional assistance locating a Medicare contract supplier contact HCAP.

If you do not use a Medicare contract supplier, your benefits will be reduced in accordance with item G in the "Impact of Medicare on this Plan" section on page 96 as amended.

Add the following as item "6. Diabetic Shoes" under "Network coverage: Paid-in-full benefit" in the "Home Care Advocacy Program" section on page 89 of your UnitedHealthcare Certificate.

6. **Diabetic Shoes – Effective April 1, 2012**, 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 pedorthist, 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 prenotification 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 third and fourth paragraphs in "Non-network benefits" under "Non-network coverage: If you do not call or if you call HCAP but do not use an HCAP provider" in the "Home Care Advocacy Program" section on page 89 of your UnitedHealthcare Certificate.

**The combined annual deductible applies:** See page 313 of your January 2013 *UnitedHealthcare Certificate Amendments* for the combined annual deductible for covered services supplied by nonparticipating providers. You must satisfy the combined annual deductible before non-network benefits will be paid for HCAP-covered services, equipment or supplies. The amount applied toward satisfaction of the combined annual deductible for non-network HCAP-covered services, equipment and supplies will be the lower of the following:

- The amount you actually paid for a medically necessary service, equipment or supplies covered under HCAP; or
- The network allowance for such service, equipment or supply.

**Non-network Benefits:** After you have satisfied the combined annual deductible, submit a claim to UnitedHealthcare. You will be reimbursed for medically necessary HCAP-covered home care services, durable medical equipment or supplies up to a maximum of 50 percent of the network allowance. You are responsible for any amounts in excess of 50 percent of the network allowance. The combined annual coinsurance maximum does not apply to HCAP.

## Managed Physical Network

Substitute the following for the heading "Deductible, coinsurance, annual maximum apply" and the first and third paragraphs of "Coinsurance and \$1,500 Annual Maximum apply" under "Non-Network benefits" in the "Managed Physical Medicine Program" section on page 92 of your UnitedHealthcare Certificate.

### **Deductible and coinsurance apply.**

**Coinsurance applies.** After you meet your deductible, submit a claim to UnitedHealthcare. You will be reimbursed up to a maximum of 50 percent of the network allowance for medically necessary services.

Your \$250 deductible and amounts applied to coinsurance under the Managed Physical Medicine Program do not count toward your combined annual deductible and coinsurance maximum.

## Infertility Benefits

Substitute the following for the last bullet under "Call The Empire Plan...for prior authorization for Qualified Procedures" in the "Infertility Benefits" section on page 93 of your UnitedHealthcare Certificate.

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).

Delete the second paragraph under "Infertility Centers of Excellence" in the "Infertility Benefits" section on page 93 of your UnitedHealthcare Certificate. The travel reimbursement process described in the paragraph has been moved to another section.

## Cancer Program

Delete the last paragraph under "What is covered" in the "Centers of Excellence for Cancer Program" section on page 94 of your UnitedHealthcare Certificate. The travel reimbursement process described in the paragraph has been moved to another section.

## Travel Allowance

Add the following after the "Centers of Excellence for Cancer Program" section on page 94 of your UnitedHealthcare Certificate.

### **Centers of Excellence Travel Allowance**

When you enroll in the Centers of Excellence for Cancer Program or are preauthorized for Infertility Benefits, you will not have to make any copayments for services performed at a qualified Center of Excellence. A travel, lodging and meal expenses benefit is available to you for travel within the United States. 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. If the patient is a minor child, the benefit will include coverage for up to two travel companions. 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. The Travel Allowance will be applied toward the \$50,000 maximum lifetime benefit for Infertility Benefits.

## General Provisions

In all instances where the terms "services and/or supplies", "services or supplies" or "services" are used, replace them with "services, supplies and/or Pharmaceutical Products", "services, supplies or Pharmaceutical Products" and "services or Pharmaceutical Products", respectively, in the "UnitedHealthcare General Provisions" section on page 94 of your UnitedHealthcare Certificate.

*Substitute the following for item "E. Dental services or supplies..." under "Exclusions" in the "UnitedHealthcare General Provisions" section on page 94 of your UnitedHealthcare Certificate.*

- E. Dental services, supplies and/or Pharmaceutical Products provided by a dentist will not be covered, except as described in the list of covered medical expenses outlined in the Participating Provider and Basic Medical Program sections. In addition, extractions, dental caries, periodontics (including but not limited to gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered.

*Substitute the following for item "P. Orthopedic shoes and other supportive devices, ..." under "Exclusions" in the "UnitedHealthcare General Provisions" section on page 95 of your UnitedHealthcare Certificate.*

- P. Orthopedic shoes and other supportive devices, and services or Pharmaceutical Products for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations.

## **Coordination of Benefits**

*Substitute the following for items 1. and 3. under "Coordination of Benefits" in the "UnitedHealthcare General Provisions" section on page 96 of your UnitedHealthcare Certificate.*

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 to other commercial coverage, 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. The amount payable under The Empire Plan plus the amount payable under the primary plan will sometimes be less than 100 percent of the allowable expense due to annual deductible and coinsurance requirements. If The Empire Plan is secondary to Medicare, the amount payable will be determined as denoted in the section entitled "Impact of Medicare on This Plan."

*Add the following as the last paragraph of "Coordination of Benefits" in the "UnitedHealthcare General Provisions" section on page 98 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.

## **Medicare**

*Substitute "domestic partner or same-sex spouse" for "domestic partner" wherever it appears in the "Impact of Medicare on this Plan" section on pages 98-99 of your UnitedHealthcare Certificate.*

*Substitute the following for the second paragraph of item "A. Retired Employees and/or their Dependents" under "Coverage" in the "Impact of Medicare on this Plan" section on page 98 of your UnitedHealthcare Certificate.*

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 items F. and G. under "Coverage" in the "Impact of Medicare on this Plan" section on page 98 of your UnitedHealthcare Certificate.

- 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.**
- G. If Medicare is your primary carrier and you live in an area that participates in the Medicare Durable Medical Equipment, Prosthetics and Orthotics Supply Competitive Bidding Program and use equipment or supplies included in the program (or get the items while visiting one of these areas), you must use a Medicare contract supplier. If you live in these areas (or get these items while visiting them) and don't use a Medicare contract supplier, Medicare will not pay for the item and your Empire Plan benefits will be reduced by the amount Medicare would have paid if you had used a contract provider. In order to maximize your benefits, it is important for you to know if you're in an area that is affected by this Medicare program. For more information you can contact Medicare at 1-800-MEDICARE (1-800-633-4227) or on the web at [www.medicare.gov](http://www.medicare.gov). If you need additional assistance locating a Medicare contract supplier contact HCAP.

## Claims Process

Substitute the following for item A. and the first paragraph of item B. under "How" in the "How, When and Where to Submit Claims" section on page 99 of your UnitedHealthcare Certificate.

- A. If you go to a participating provider, MPN Network provider, HCAP-approved provider or a Basic Medical 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 nonparticipating 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 120 days after the end of the calendar year in which covered medical expenses were incurred or 120 days 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 items A. and B. under "When" in the "How, When and Where to Submit Claims" section on page 100 of your UnitedHealthcare Certificate.

- A. If you use a participating provider, MPN Network provider, HCAP-approved provider or a Basic Medical Discount Program Provider, your provider will submit a claim to UnitedHealthcare.
- B. If you use a nonparticipating 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 120 days after the end of the calendar year in which covered medical expenses were incurred or 120 days 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.

## Overpayments

*Substitute the following for the last paragraph under "Refund to UnitedHealthcare for overpayment of benefits" in the "Miscellaneous Provisions" section on page 103 of your UnitedHealthcare Certificate.*

### 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.

### Utilization Review Guidelines

*Add the following immediately before the "Appeals" section on page 103 of your UnitedHealthcare Certificate.*

If we have all the information necessary to make a determination regarding a preadmission or prospective procedure review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to preadmission or prospective procedure review of urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

**Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified previously for preadmission or prospective procedure review of urgent claims.

If we have already approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

**Retrospective Reviews.** If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it

within 30 calendar days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

**Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not medically necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our determination, date of service, provider name and claim amount (if applicable). The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you (or your designee) and your provider of our decision by telephone and in writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information.

When we receive a request for home health care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home health care services, either on the basis of medical necessity or for failure to obtain prior authorization, while our decision on the request is pending.

## Appeals

*Substitute the following for the "Appeals" section on pages 103-106 of your UnitedHealthcare Certificate.*

You or another person acting on your behalf may submit an appeal. If a post service claim (a claim for benefits payment after medical care has been received) or a preservice request for benefits (including a request for benefits that requires notification, precertification or benefit confirmation prior to receiving medical care) is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal by writing to:

UnitedHealthcare  
PO Box 1600  
Kingston, New York 12402-1600

Or, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program, Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time.

### Appeal process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with UHC's Medical Director or a health care professional with appropriate expertise who is credentialed by the national accrediting body appropriate to the profession in that field, and who was not involved in the prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefit. In addition, if any new or additional evidence is relied upon or generated by UnitedHealthcare during the determination of the appeal, it will be provided to you free of charge and sufficiently in advance of the due date of the decision of the appeal.

### Level 1 Appeals

A request for review must be directed to UnitedHealthcare within 180 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, you should state the reason why you believe the claim determination or precertification improperly reduced or denied your benefits. Also,

submit any data or comments to support the appeal of the original determination as well as any data or information requested by UnitedHealthcare. A written acknowledgment of your appeal will be sent to you within 15 days after it is received.

For a first level appeal of a post service claim, a review of the appeal will be done and within 30 days of your request, UnitedHealthcare will provide you with a written decision.

For a first level appeal of a preservice request for benefits, a review of the appeal will be done and within 15 days of your request, UnitedHealthcare will provide you with a written decision.

If the determination is upheld, UnitedHealthcare's written response will cite the specific Plan provision(s) upon which the denial is based and will include both of the following:

- Detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.
- Notification of your right to a further review.

## **Level 2 Appeals**

If, as a result of the Level 1 review, the original determination of benefits is upheld by UnitedHealthcare, in whole or in part, you can request a Level 2 review. This request should be directed either in writing or by telephone to UnitedHealthcare within 60 days after you receive notice of the Level 1 appeal determination. When requesting the Level 2 review, you should state the reasons you believe the benefit reduction or denial was improperly upheld and include any information requested by UnitedHealthcare along with any additional data, questions or comments deemed appropriate.

For a second level appeal of a post service claim, a review of the appeal will be done and within 30 days of your request, UnitedHealthcare will provide you with a written decision.

For a second level appeal of a preservice request for benefits, a review of the appeal will be done and within 15 days of your request, UnitedHealthcare will provide you with a written decision.

If the determination is upheld, UnitedHealthcare's written response will cite the specific Plan provision(s) upon which the denial is based and will provide detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.

**Appeals involving urgent situations:** If an appeal involves a situation in which a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain, the appeal will be resolved and you will be notified of the determination in no more than 72 hours following receipt of the appeal. Notice of the determination will be made directly to the person filing the appeal (you or the person acting on your behalf).

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

## **External Appeals**

### **Your right to an External Appeal**

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if UnitedHealthcare has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, 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 Financial Services to conduct such appeals.

## **Your right to an Immediate External Appeal**

If we fail to adhere to the utilization review requirements described in your Certificate, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in your Certificate.

## **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 previously and if any new or additional information regarding the service or procedure was presented for consideration, UnitedHealthcare must have upheld the denial or you and UnitedHealthcare 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 previously and if any new or additional information regarding the service or procedure was presented for consideration, UnitedHealthcare must have upheld the denial or you and UnitedHealthcare must agree in writing to waive any internal appeal.

Your attending physician must certify that you have a condition/disease whereby 1) standard health services or procedures have been ineffective or would be medically inappropriate, or 2) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or 3) for which there exists a clinical trial or rare disease treatment.

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 Financial Services to obtain current information about what documents will be considered acceptable); 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 condition or disease.

**Your right to appeal that a service should be covered since it is considered a rare disease** is defined as a condition:

- That is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or affects fewer than 200,000 United States residents per year; and
- For which there are no standard health services or procedures covered by the health care plan that are more clinically beneficial than the requested service or treatment.

As part of the external appeal process for rare diseases, a physician other than the member's treating physician, must certify in writing that the condition is a rare disease. The certifying physician must be a licensed, board-certified or board-eligible physician specializing in the appropriate area of practice to treat the rare disease. The physician's certification must provide either that the rare disease:

- Is or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
- Affects fewer than 200,000 United States residents per year.

The certification is to rely on medical and scientific evidence to support the requested service or procedure (if such evidence exists) and must include a statement that, based on the physician's credible experience, there is no standard treatment that will be more clinically beneficial to the member. The statement must also indicate that the requested service or procedure is likely to benefit the member in the treatment of their rare disease and that the benefit outweighs the risks of the service or procedure.

**The External Appeal process:** If, through the internal appeal process described previously, 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 four months from receipt of such notice to file a written request for an external appeal. If you and UnitedHealthcare have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. UnitedHealthcare will provide an external appeal application with the final adverse determination issued through UnitedHealthcare's internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services 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 UnitedHealthcare based its denial, the External Appeal Agent will share this information with UnitedHealthcare in order for it to exercise its right to reconsider its decision. If UnitedHealthcare chooses to exercise this right, UnitedHealthcare will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), UnitedHealthcare 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 UnitedHealthcare. 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 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and UnitedHealthcare 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 UnitedHealthcare's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, UnitedHealthcare 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, UnitedHealthcare will only cover the costs of services required to provide treatment to you according to the design of the trial. UnitedHealthcare shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth-care services, the costs of managing research, or costs that would not be covered under the Policy for nonexperimental or noninvestigational treatments provided in such clinical trial.

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

You will be charged a fee of \$25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. UnitedHealthcare 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 Financial Services. 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.

### **Four-month External Appeal deadline**

Under New York State law, your completed request for external appeal must be received by the Department of Financial Services within four months (with an additional eight days allowed for mailing) of the date of the Final Notice of Adverse Determination of the first level appeal or the date upon which you receive a written waiver of any internal appeal. UnitedHealthcare has no authority to grant an extension of this deadline.

# EMPIRE PLAN MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM: CERTIFICATE AMENDMENTS

*Substitute the following for the UnitedHealthcare Insurance Company of New York Certificate of Insurance on pages 181-209 of your Empire Plan Certificate as amended in your January 2008 Empire Plan Report.*

## **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, 2012 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

# UNITEDHEALTHCARE CERTIFICATE OF INSURANCE

## Empire Plan Mental Health and Substance Abuse Program

### 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.

The Empire Plan Mental Health and Substance Abuse Program has two levels of benefits for covered services: network coverage and non-network coverage. Review the benefits and exclusions in this Certificate before you obtain services. Please refer to the "Schedule of Benefits for Covered Services" for a complete description of the two benefit levels. Excluded services and conditions will not be covered under the Program. Please review "Exclusions" for a complete description.

### Coverage

Covered services for medically necessary mental health and substance abuse care, 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);
- Outpatient mental health services;
- Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment;
- Substance abuse structured outpatient rehabilitation and aftercare;
- Electroconvulsive therapy;
- Medication management;
- Ambulance services;
- Psychiatric second opinions; and
- Applied Behavior Analysis with a confirmed diagnosis of Autism Spectrum Disorder (effective January 1, 2013)

**IMPORTANT:** See your *NYSHIP General Information Book and Empire Plan Certificate* for other conditions that may affect this coverage.

**If you have questions about the Empire Plan Mental Health and Substance Abuse Program, you or a member of your family or household may call OptumHealth at 1-877-769-7447 and choose the Mental Health and Substance Abuse Program.**

Calling OptumHealth is the first step in ensuring that you will be eligible to receive the highest level of benefits. 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.

By making the call before you receive services, and then obtaining care from a provider referred to you by OptumHealth, you will receive the highest level of benefit with 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.

## Meaning of Terms Used

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. **Applied Behavior Analysis (ABA)** means a behavioral approach that seeks to reinforce adaptive behaviors and reduce maladaptive behaviors commonly used with children with Autistic Spectrum Disorders. ABA includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.
- B. **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 listed previously and admission is certified by OptumHealth.

- C. **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.
- D. **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.
- E. **Clinical Referral Line** means the clinical resource and referral service that you may call prior to receiving any covered services to obtain network referrals or benefit information. 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 the Mental Health and Substance Abuse Program.
- F. **Coinsurance** means, for Approved Facility services, the difference between the billed charge and the percentage covered; and, for non-network practitioner services, the difference between the reasonable and customary charge and the percentage covered. The Plan's coinsurance maximum is shared between Basic Medical, the Hospital Program and the Mental Health and Substance Abuse Program. **Note:** Copayments paid to a network practitioner count toward meeting your plan coinsurance maximum.
- G. **Combined Annual Coinsurance Maximum** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each calendar year, for coinsurance amounts incurred under the Basic Medical, Hospital and Mental Health and Substance Abuse (MHSA) Programs. Copayments for Participating Provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum. After the combined annual coinsurance maximum is reached, benefits are paid at 100 percent of reasonable and customary charges for non-network covered services.
- H. **Combined Annual Deductible** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each calendar year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program expenses and/or non-network Mental Health and Substance Abuse Program expenses before benefits will be paid under these components of the Plan.

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

1. The amount you actually paid for a medically necessary service under the non-network portion of the Program; or
  2. For Practitioner services, the reasonable and customary charge; or
  3. For Approved Facility services, the billed amount for such service.
- I. **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, licensed 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.
- J. **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. **Note:** Copayments paid to a network practitioner count toward meeting your plan coinsurance maximum.
- K. **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.
- L. **Covered Expenses** means:
1. Under the network portion of the Program, the network allowance for any medically necessary covered services provided to you by a network provider.
  2. Under the non-network portion of the Program, the reasonable and customary charge by a non-network practitioner. These services must be medically necessary as defined in this section. No more than the reasonable and customary charge will be considered by the program for medically necessary covered services. More detail on covered expenses is provided in the section "Schedule of Benefits for Covered Services."

A covered expense is incurred on the date the service is received by you.

Charges for services performed by a person or facility **not** listed in the definition of practitioner or approved facility are **not** covered expenses under the program. A more detailed description of covered expenses and exclusions is provided on the following pages.

- M. **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.
- N. **Crisis Intervention Visits** means visits for stabilization of an acute emotional disturbance that requires immediate attention to a patient in high distress.
- O. **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.

P. **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.

Q. **Intensive Outpatient Program (IOP):** is a freestanding or hospital-based program that provides medically necessary services more than once weekly. Intensive outpatient programs are used as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospital program. Intensive outpatient programs can be used to treat mental health conditions or substance abuse disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-use disorders.

R. **Medically Necessary** means a service that 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.

S. **Mental Health Care** means medically necessary care rendered by a covered 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*.

T. **Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you, including applicable copayments under The Empire Plan Mental Health and Substance Abuse Program.

U. **Network Coverage** means the level of benefits provided by the Program when you receive medically necessary services from a network provider or a provider recommended to you by OptumHealth.

V. **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 a facility 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.

W. **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.

- X. **Network Provider** means either a network practitioner or a network facility.
- Y. **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.
- Z. **Non-Network Facility** means an approved facility that has not entered into an agreement with OptumHealth as an independent contractor to provide covered services to you.
- AA. **Non-Network Practitioner** means a practitioner who has not entered into an agreement with OptumHealth as an independent contractor to provide covered services to you. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by OptumHealth.
- BB. **Non-Network Provider** means a practitioner or approved facility that has not entered into an agreement with OptumHealth to provide covered services to you.
- CC. **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.
- DD. **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.
- EE. **Partial Hospitalization** means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than four hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay. An approved facility 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.
- FF. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who renders medical necessity decisions.
- GG. **Practitioner** means:
  1. A psychiatrist; or
  2. A psychologist; or
  3. A licensed clinical social worker in New York State with the "R" privilege. 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: an Advanced Practice nurse who holds a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; 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 psychiatrist. Nurse Practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. **Benefits for these services are available under network coverage only.**

6. Applied behavior analysis provider or ABA provider means: A licensed provider who is certified as a behavior analyst pursuant to a behavior analyst certification board. For ABA services only, licensed provider means a psychiatrist, psychologist or licensed clinical social worker, or an individual licensed or otherwise authorized under Education Law Title VIII to practice a profession for which ABA is within the scope of that profession. Coverage for ABA by a licensed provider and certified behavior analyst does not extend to basic behavioral health coverage or non-ABA services.
7. ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a licensed provider and certified behavior analyst. An ABA Agency may also employ ABA aides to deliver the treatment protocol of the ABA provider. Coverage of behavioral health services by an ABA Agency or ABA Aide does not extend to basic behavioral health coverage or to non-ABA services.

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

II. **Provider** means a practitioner or 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 that 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.

JJ. **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.

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

LL. **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, including an aftercare component of weekly follow-up. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

MM. **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; and

2. Substantially or materially impairs a person's ability to function in one or more major life activities; and
3. Is a condition that 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.

NN. **Total Disability** and **Totally Disabled** means 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.

OO. **UHIC-NY** means UnitedHealthcare Insurance Company of New York, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.

PP. **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

The Mental Health and Substance Abuse Program has two levels of benefits: network coverage and non-network coverage.

### Network Coverage

Using a network provider offers you the highest benefit level under The Empire Plan.

1. Network providers have been credentialed by OptumHealth, so you know they meet high standards of education, training and experience.
2. Non-network providers can bill you for amounts significantly over the amount reimbursed by OptumHealth. A network provider has agreed to accept the network allowance, plus your copayment, if applicable.
3. You will have no claims to file. Network providers collect only a copayment from you.

By using a network provider, you will receive network coverage for medically necessary treatment. 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. For assistance with identifying a network provider, who can meet your needs, call the OptumHealth *Clinical Referral Line* 24 hours a day, any day of the year at 1-877-7-NYSHIP (1-877-769-7447).

You are guaranteed access to network benefits. If you cannot locate a network provider in your area, contact the *Clinical Referral Line*. By using a provider that OptumHealth refers you to, you will receive network benefits even if the provider is not in the network.

**Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Program.**

### Non-Network Coverage

Before you choose a non-network provider, consider the high cost of treatment. **If you choose or use a non-network provider, it is your responsibility to ensure that the non-network provider obtains required certification of services provided to you.**

For a nonemergency inpatient admission to a non-network facility, you must call OptumHealth before the admission to have the medical necessity of the admission certified. This requirement applies nationwide even if another plan is your primary coverage.

Most outpatient services do not need prior certification (see “Schedule of Benefits for Covered Services”). However, all care is subject to review under the program’s medical necessity guidelines. When using a non-network provider, it is your responsibility to ensure that your provider responds to OptumHealth’s requests for the information necessary to review and certify coverage for the services you receive from that provider.

**Out-of-pocket expenses:** When you use a non-network provider you are responsible for the deductible and any difference between the amount billed and the amount you are reimbursed under this Program.

To be certain that your care is medically necessary when you choose to use a non-network provider, you should call OptumHealth to start the certification process prior to receiving services, or as soon as is reasonably possible.

**If your inpatient or outpatient treatment is determined to be not medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.**

### **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 \$70 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this \$70 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.

### **Show your identification card**

You may be required to show your Empire Plan Benefit 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.

## **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. 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.

- 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 or Substance Abuse treatment in a **partial hospitalization** program (day or night care center) and Intensive Outpatient programs, maintained by an approved facility, on its premises, are covered.
- D. **Psychiatric Treatment or Consultation While You Are in 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. This benefit will be paid under the inpatient care benefit according to network status of the treating practitioner.

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. This benefit will be paid under the inpatient care benefit according to network status of the treating practitioner.

- 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. This benefit will be paid under the inpatient care benefit according to network status of the treating practitioner.
- F. **Prescription drugs,** 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 under the Mental Health and Substance Abuse Program.

## 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 disorders, 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 medically necessary mental health care.
- C. **Psychiatric Second Opinion.** You are covered for a second opinion 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 covered by 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 covered for up to 20 family sessions (per calendar year), subject to OptumHealth certification.
- E. **Substance Abuse-Structured Outpatient Rehabilitation Program.** Substance Abuse Structured Outpatient Rehabilitation Program benefits are covered.
- F. **Psychological Testing and Evaluations.** These services are covered if OptumHealth certifies that they are medically necessary for the condition(s) indicated. 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.
- G. **Ambulance Services for Mental Health and Substance Abuse Care.** Emergency ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and ambulance transportation is required because

of an emergency condition. Nonemergency transportation is covered, when medically necessary, if provided by a licensed ambulance service. The following covered medical expenses for ambulance service apply:

1. Local emergency ambulance charges are not subject to deductible or coinsurance.
2. When the enrollee has no obligation to pay for the use of an organized voluntary ambulance service, donations up to a maximum of \$50 for services less than 50 miles, \$75 for 50 miles or over. These amounts are not subject to copayment, deductible or coinsurance.

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.** Under network coverage, Crisis Intervention Visits are payable in full up to the network allowance for up to three visits in a given crisis. OptumHealth may request documentation in order to determine if visits are considered crisis intervention. **Paid-in-full benefits for these services are available under network coverage only.**
- I. **Electroconvulsive Therapy.** Electroconvulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All Electroconvulsive therapy must be certified by OptumHealth before the service is received.
- J. **Medication Management.** You are covered for office visits to a psychiatrist or registered network nurse practitioner for the ongoing review and monitoring of medications used to treat mental health or psychiatric conditions. **Benefits for nurse practitioners are available under network coverage only.**
- K. **Home-Based Counseling.** You are covered for **medically necessary** home-based counseling provided by network practitioners and following all outpatient procedures as practiced in outpatient office visits. **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 psychiatrist are covered under the Plan when medically necessary. Nurse practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. **Benefits for these services are available under network coverage only.**
- M. **Telephone Counseling. Medically necessary** telephone counseling provided by a network practitioner is covered. **Benefits for these services are available under network coverage only.**
- N. **Applied Behavior Analysis (ABA). Effective January 1, 2013,** services must be provided by or supervised by a licensed provider who is also a Certified Behavior Analyst. The network provider **must** obtain OptumHealth certification of this care **before** services begin. If services are being provided by a non-network provider, you **must** have your practitioner call OptumHealth and obtain certification of the care **before** services begin.

### **OptumHealth reviews outpatient and inpatient 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 mental health and substance abuse benefits to continue.**

**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. This information will also be provided to you in writing. You will have 180 days to request an appeal.

When you or your provider requests an appeal involving a clinical matter, a different 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 60 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 from OptumHealth. Panel members must not have 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: 180-day deadline" for additional information.

If an appeal involves an administrative matter, it will be reviewed by an employee of OptumHealth with problem-solving authority above that of the original reviewer. Administrative appeals are reviewed by OptumHealth, in consultation with UHIC-NY as needed.

## Schedule of Benefits for Covered Service

**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. You pay the first \$20 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.
- B. 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
  - Electroconvulsive 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
- C. You pay the first \$70 charged for emergency care in a hospital emergency room. You will not have to pay this \$70 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.
- D. **Effective January 1, 2013:** You pay the first \$20 charged for each visit for approved ABA therapy for Autism Spectrum Disorder. One copayment per visit will apply for all covered ABA services rendered during that visit.

**Note:** Copayments paid to a network provider count toward meeting your Empire Plan combined annual coinsurance maximum.

Your payment to the network provider is limited to your copayment. Except for the copayment that the network provider obtains directly from you, a network provider cannot bill you directly for services you obtain as a network benefit. 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

When you use a provider that is not in the network or not referred to you by OptumHealth, OptumHealth pays the following covered percentages:

- A. For Practitioner Services: 80 percent of reasonable and customary charges for covered services after you meet the Empire Plan combined annual deductible. The covered percentage becomes 100 percent of the reasonable and customary charge for covered services once The Empire Plan combined annual coinsurance maximum is met.
- B. For Approved Facility Services: 90 percent of billed charges for covered services. The covered percentage becomes 100 percent of the billed charges for covered services once The Empire Plan combined annual coinsurance maximum is met.

The Empire Plan **combined annual deductible** is \$1,000 for the enrollee, \$1,000 for the enrolled spouse/ domestic partner and \$1,000 for all dependent children combined. The combined annual deductible must be met before your claims can be reimbursed.

The Empire Plan **combined annual coinsurance maximum** is \$3,000 for the enrollee, \$3,000 for the spouse/ domestic partner and \$3,000 for all dependent children combined.

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

### Maximums

Mental Health and Substance Abuse coverage is unlimited (no maximum) for medically necessary 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.

Coverage for applied behavior analysis is limited to \$45,000 for the 2013 plan year.

### 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 that are not medically necessary as defined in the section "Meaning of Key Terms."
- C. Treatment that is not Mental Health Care or Substance Abuse Care as defined in the section "Meaning of Key Terms."
- D. Services that 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 that 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 program 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 – Custodial care means the spectrum of clinical and non-clinical services provided expressly for protection and monitoring in a controlled environment, regardless of setting, that do not seek a cure once the signs and symptoms of the patient have been stabilized, resolved or at baseline level of functioning or the patient is not responding to treatment or otherwise not improving. Examples include but are not limited to:
- Respite services;
  - State hospital care that is custodial for children who are wards of the state;
  - Enrollees or eligible dependents who are incarcerated in a state hospital facility;
  - Days awaiting placement;
  - Activities that are social and recreational in nature;
  - Used solely to prevent runaway/truancy or legal problems.
- 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 that 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 that 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.
- S. Coverage for ABA by a licensed provider and certified behavior analyst does not extend to basic behavioral health coverage or non-ABA services. Coverage of behavioral health services by an ABA Agency or ABA Aide does not extend to basic behavioral health coverage or to non-ABA services.
- T. ABA services are not a covered benefit when provided pursuant to an individualized education plan (IEP) under Article 89 of the education law, or under an individualized family service plan (IFSP) or an individualized services plan. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act is not a covered benefit.

### **Coordination of Benefits**

If you are covered by an additional group health insurance program (such as a program provided by your spouse’s employer) that 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 that 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 as follows. 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 that 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 coverage 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 nongovernmental 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.
- 3. 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 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 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.)
    - 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., 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 that 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 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 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 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 that 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 that 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**

#### **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 mental health and substance abuse benefits that will be payable to you first.
- C. **Secondary Payor** means a plan that will determine your mental health and substance abuse 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 your *NYSHIP General Information 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 your NYSHIP General Information 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 mental health and substance abuse 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.”**

- 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 mental health and substance abuse 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 or same-sex spouse eligible for Medicare due to age) unless end-stage renal disease provisions apply; Medicare is the secondary payor. As the primary payor, UHIC-NY will pay benefits for covered mental health and substance abuse 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 or same-sex spouses:** Under Social Security law, Medicare is primary for an active employee’s domestic partner or same-sex spouse who becomes Medicare eligible at age 65. If the domestic partner or same-sex spouse 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 your *NYSHIP General Information Book*. 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 nongovernmental 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 nongovernmental 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 mental health and substance abuse 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 mental health and substance abuse 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 that 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 your agency Health Benefits Administrator or by calling The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choosing The Mental Health and Substance Abuse Program. You may also download a claim form from the New York State Department of Civil Service web site at <https://www.cs.ny.gov> or from The Empire Plan's Mental Health and Substance Abuse Program's enrollee web site at [www.liveandworkwell.com](http://www.liveandworkwell.com).

### 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.

**Benefits will not be paid for claims submitted after the 120 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). Claims must be submitted to either OptumHealth or Medicare, if applicable, within 120 days 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 120 days after Medicare processes the claim.**

Make and keep a duplicate copy of the "Explanation of Medicare Benefits" form and other documents for your records.

- 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 combined annual deductible before the claims are paid.

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

### 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  
PO Box 5190  
Kingston, NY 12402-5190

### Fraud

**Any person who intentionally defrauds an insurance company by filing a claim that contains false or misleading information, or conceals information that 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 the Mental Health and Substance Abuse Program.

## 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 inpatient facility for care or mental health or substance abuse treatment or are confined at home under the care of a practitioner for mental health or substance abuse treatment, 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.

### 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 inpatient 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 that 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 that is incurred before your coverage ends will not be affected.

### 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*.

### 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 that 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.

### **Utilization Review Guidelines**

If we have all the information necessary to make a determination regarding a preadmission or prospective procedure review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to preadmission or prospective procedure review of urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

**Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified previously for preadmission or prospective procedure review of urgent claims.

If we have already approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

**Retrospective Reviews.** If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

**Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not medically necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our determination, date of service, provider name and claim amount (if applicable). The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

## Appeals

### Appeals: 180-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 180 days after you receive a notice of denial of the certification or claim to:

OptumHealth  
Attn: Appeals Dept.  
PO Box 5190  
Kingston, NY 12402-5190

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. Upon request to OptumHealth and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefit. In addition, if any new or additional evidence is relied upon or generated by OptumHealth during the determination of the appeal, it will be provided to you free of charge and sufficiently in advance of the due date of the decision of the appeal.

Please refer to "Certification denial and appeal process: deadlines apply" on page 342 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 Department of Financial Services at: New York State Department of Financial Services, One Commerce Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday through Friday, 9 a.m. to 5 p.m., 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 Financial Services 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 (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), 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 previously 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 previously 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 attending physician must also certify that you have a condition/disease whereby 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 or rare disease treatment (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 Financial Services to obtain current information about 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 condition or disease.

### **The External Appeal process**

If, through the internal appeal process described previously, 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 four months 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 four months 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 previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services 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 in the following), 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 72 hours 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 nonhealth-care services, the costs of managing research, or costs that would not be covered under the Policy for nonexperimental or noninvestigational 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.

You will be charged a fee of \$25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. OptumHealth 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 Financial Services. 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.

### **Four-month deadline**

Under New York State law, your completed request for appeal must be filed within four months 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: CERTIFICATE AMENDMENTS

*Substitute the following for the Empire BlueCross BlueShield Certificate of Insurance on pages 210-224 of your January 2008 Empire Plan Report.*

The Empire Plan Prescription Drug Program Certificate does not apply to Medicare-primary Empire Plan enrollees and dependents enrolled in the Empire Plan Medicare Rx Prescription Drug Plan (PDP). For further information regarding your Empire Plan Medicare Rx benefits, see your **Evidence of Coverage** and **Empire Plan Medicare Rx (PDP) Plus Certificate**.

## **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, 2012 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 represented by the Agency Police Services Unit (APSU) 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 INSURANCE COMPANY OF NEW YORK

## CERTIFICATE OF INSURANCE

### Empire Plan Prescription Drug Program

UnitedHealthcare Insurance Company of New York insures and jointly administers The Empire Plan Prescription Drug Program (the "Program"). UnitedHealthcare utilizes the administrative and mail distribution services of Express Scripts, Inc./Medco Health Solutions, Inc. (Express Scripts/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. **Ancillary Charge** means the amount, in addition to, the applicable copayment an enrollee will pay when purchasing a Brand-Name Drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the discounted ingredient cost of the dispensed Brand-Name Drug and the discounted ingredient cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug. The Ancillary Charge does not apply if an appeal of the mandatory generic substitution requirement is approved by UnitedHealthcare; however, the enrollee must pay the applicable Non-Preferred Brand copayment.
- B. **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.
- C. **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.
- D. **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.
- E. **Controlled Drug** means a drug 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.
- F. **Designated Specialty Pharmacy** means a pharmacy that has entered into an agreement with Express Scripts/Medco to provide specific Specialty Drugs/Medications. The Empire Plan's Designated Specialty Pharmacy is Accredo Pharmacy.
- G. **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.

- H. **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.
- I. **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.
- J. **First Fill** means an enrollee's initial or very first dispensing of a Specialty Drug/Medication covered under The Empire Plan Specialty Pharmacy Program.
- K. **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.
- L. **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.
- M. **Grace Fill for Specialty Drugs** means that an enrollee is allowed to have the First Fill of a Specialty Drug/Medication dispensed from a Pharmacy other than the Designated Specialty Pharmacy.
- N. **Mail Service Pharmacy** means all facilities that are owned, operated or affiliated with Express Scripts/ 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.
- O. **Medically Necessary Drug** means any drug that, as determined by UnitedHealthcare, 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 provisions listed previously do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

- P. **Network Pharmacy** means a Pharmacy, other than a Mail Service Pharmacy or the Designated Specialty Pharmacy, that has entered into a contract with Express Scripts/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.
- Q. **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.
- R. **Non-Network Pharmacy** means any Pharmacy, other than a Mail Service Pharmacy, that has not entered into a contract with Express Scripts/Medco to dispense drugs. The Enrollee must file a claim form with UnitedHealthcare in order to receive reimbursement for covered drugs received from a Non-Network Pharmacy.
- S. **Non-Preferred Drug** means a Brand-Name Drug that is not subject to a Level 1 or Level 2 copayment on The Empire Plan Flexible Formulary drug list by UnitedHealthcare.
- T. **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.
- U. **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.
- V. **Preferred Drug** means a Brand-Name Drug that is subject to a Level 1 or Level 2 copayment on The Empire Plan Flexible Formulary drug list by UnitedHealthcare.
- W. **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.
- X. **Program** means The Empire Plan Prescription Drug Program described in this Certificate.
- Y. **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.
- Z. **Therapeutic Category** means categories by which drugs are identified and grouped by the main conditions they treat.
- AA. **Therapeutic Equivalent** means prescription drug products that, when compared, can be expected to produce essentially the same therapeutic outcome and toxicity as determined by UnitedHealthcare.
- AB. **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.
- AC. **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 *NYSHIP General Information Book*.

The information that follows explains your benefits and responsibilities in detail.

## Your Benefits and Responsibilities

### Copayments

**Effective April 1, 2012.** Copayments for covered drugs are based on the drug, the days' supply and whether the Prescription is filled at a Network Pharmacy, Mail Service Pharmacy or the Designated Specialty Pharmacy. Most Level 1 contraceptive drugs and devices are not subject to copayment.

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

- **\$5** for most **Generic** Drugs or Level 1 Drugs
- **\$25** for **Preferred** Drugs, Compound Drugs or Level 2 Drugs
- **\$45** for **Non-Preferred** Drugs, certain **Generic** Drugs or Level 3 Drugs

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

- **\$10** for most **Generic** Drugs or Level 1 Drugs
- **\$50** for **Preferred** Drugs, Compound Drugs or Level 2 Drugs
- **\$90** for **Non-Preferred** Drugs, certain **Generic** Drugs or Level 3 Drugs

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 most **Generic** Drugs or Level 1 Drugs
- **\$50** for **Preferred** Drugs, Compound Drugs or Level 2 Drugs
- **\$90** for **Non-Preferred** Drugs, certain **Generic** Drugs or Level 3 Drugs

**Note:** Oral cancer chemotherapy drugs for the treatment of cancer do not require copayment.

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 copayment plus the Ancillary Charge, 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, that in most cases will be the Non-Preferred 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, UnitedHealthcare will adjust claims processed by a pharmacy within 30 days from the date UnitedHealthcare 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 UnitedHealthcare.

### **Empire Plan Flexible Formulary**

**Effective April 1, 2012**, 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 most covered Generic Drugs and certain Brand-Name drugs.
- B. Level 2 drugs have the mid-range copayment and include Preferred Drugs that have been selected because of their overall healthcare value.
- C. Level 3 drugs have the highest copayment and include Non-Preferred Drugs.

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

- A. When advantageous to the Plan, the Brand-for-Generic feature allows a Brand-Name drug to be placed on Level 1, the lowest copayment level, and the new generic equivalent to be placed on Level 3, the highest copayment level, or excluded. These placements are for a limited time, typically six months, and may be revised mid-year when such changes are advantageous to The Empire Plan.
- 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 that 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.

## New to You Prescriptions

**Effective January 1, 2013**, for certain maintenance medications, at least two 30-day supplies must be filled using your Empire Plan Prescription Drug Program benefits before a supply for greater than 30 days will be covered. If you attempt to fill a prescription for a new maintenance medication for more than a 30-day supply at a Network or Mail Service Pharmacy, the last 180 days of your prescription history will be reviewed to determine whether at least 60 days' worth of the drug has been previously dispensed. If not, only a 30-day fill will be approved.

## 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, UnitedHealthcare will request from your Doctor the clinical information required to authorize coverage of the medication. Your Pharmacy or Doctor may contact UnitedHealthcare to begin the authorization process. UnitedHealthcare 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:

- |             |                           |            |              |                     |
|-------------|---------------------------|------------|--------------|---------------------|
| • Abstral   | • Egrifta                 | • Infergen | • Orenzia    | • Tracleer          |
| • Actemra   | • Enbrel                  | • Intron-A | • Pegasys    | • Tysabri           |
| • Actiq     | • Epogen/Procrit          | • Kalydeco | • Peg-Intron | • Tyvaso            |
| • Adcirca   | • fentanyl citrate powder | • Kineret  | • Provigil   | • Veletri           |
| • Ampyra    | • Fentora                 | • Korlym   | • Rebif      | • Ventavis          |
| • Aranesp   | • Flolan                  | • Kuvan    | • Remicade   | • Victrelis         |
| • Aubagio   | • Forteo                  | • Lamisil  | • Remodulin  | • Weight Loss Drugs |
| • Avonex    | • Gilenya                 | • Lazanda  | • Revatio    | • Xeljanz           |
| • Betaseron | • Growth Hormones         | • Letairis | • Simponi    | • Xeomin            |
| • Botox     | • Humira                  | • Makena   | • Sporanox   | • Xolair            |
| • Cayston   | • Immune Globulins        | • Myobloc  | • Stelara    | • Xyrem             |
| • Cimzia    | • Incivek                 | • Nuvigil  | • Subsys     |                     |
| • Copaxone  | • Increlex                | • Onmel    | • Synagis    |                     |
| • Dysport   |                           | • Onsolis  | • Tecfidera  |                     |

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 that follows or go to the New York State Department of Civil Service web site at <https://www.cs.ny.gov>. 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

**Effective April 1, 2012**, 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 Fill 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.ny.gov> 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 you will be responsible for the difference between the amount charged and amount you are reimbursed under this Program. 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 that 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 following section "Exclusions and Limitations" for conditions under which benefits 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(1)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 nonhealth-care services, the costs of managing research or costs not otherwise covered by The Empire Plan for nonexperimental or noninvestigational 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: Acuvail, Adoxa, Altoprev, amlodipine/atorvastatin (generic Caduet), Amrix, Analpram Advanced Kit, Androgel, Aplenzin, Aricept 23 mg, Asacol HD, Atelvia, Axiron, BenzEfoam, Bromday, Caduet, Cambia, carisoprodol 250 mg (generic Soma 250 mg), Centany AT, Clindacin PAC, Clindagel, clobetasol propionate shampoo (generic Clobex Shampoo), Clobex Shampoo, ConZip, Coreg CR, cyclobenzaprine extended release capsule (generic Amrix), Detrol LA, Dexilant, Doryx, doxycycline hyclate extended release tablet (generic Doryx), doxycycline monohydrate 150 mg capsule (generic Adoxa 150 mg capsule), Duexis, Edluar, Epiduo, Exforge, Exforge HCT, Extavia, fenofibrate 48 mg and 145 mg (generic Tricor), Flector, Flo-Pred, Fortesta, 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), Jalyn, lansoprazole capsule, levalbuterol inhalation solution (generic Xopenex Inhalation Solution), Lorzone, Metozolv ODT, Momexin Kit, Morgidox Kit, Naprelan, Neobenz Micro, Nexium, Norditropin (except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age), Oleptro ER, Olux/Olux-E Complete Pack, omeprazole/sodium bicarbonate capsule (generic Zegerid), Omnitrope (except for the treatment of growth failure due to Prader-Willi Syndrome or Small for Gestational Age), Orbivan, Pacnex HP/Pacnex LP/Pacnex MX, Pennsaid, Pramoxone E, Prevacid Capsule, ProCort, Requip XL, ropinirole extended release (generic Requip XL), Rybix ODT, Ryzolt, Silenor, Soma 250, Sumaxin TS, Terbinex, Tobradex ST, tramadol extended release tablet (generic Ryzolt), Treximet, Triaz, Tribenzor, Tricor, Trilipix, Twynsta, Uramaxin GT/Kit, Veltin, Veramyst, Vimovo, Xerese, Xopenex Inhalation Solution, Zegerid capsule, Ziana, Zipsor, Zolpimist, Zolvit, Zuplenz and Zyclara.
- 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.ny.gov> 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 anorexiant, 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 U.S. 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 four ways: at a Network Pharmacy, at a Non-Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy.

### 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.ny.gov>.

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 expenses, 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.ny.gov>.

Mail the completed form with your bills or receipts to:

The Empire Plan Prescription Drug Program  
c/o ESI/Medco  
PO 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, that in most cases will be the Non-Preferred copayment.

### Deadline for filing claims

Claims must be submitted within 120 days after the end of the calendar year in which the prescription drugs were purchased, or 120 days 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  
PO 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.ny.gov>.) 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.

UnitedHealthcare 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.ny.gov> 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 Express Scripts/ 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.ny.gov>, select Benefit Programs and follow the prompts to NYSHIP Online. Then choose Find a Provider and scroll to the Express Scripts/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) are 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 nongovernmental 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.)
    - 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

**Effective January 1, 2013**, NYSHIP replaced The Empire Plan Prescription Drug Program coverage for Medicare-primary enrollees and Medicare-primary dependents with Empire Plan Medicare Rx (PDP), a Medicare Part D prescription drug program with expanded coverage designed especially for NYSHIP. This prescription drug coverage is insured by UnitedHealthcare and jointly administered by Express Scripts/Medco. Eligible individuals are enrolled automatically in Empire Plan Medicare Rx. Prior to enrollment, affected enrollees and dependents will receive important plan benefit information from the New York State Department of Civil Service and UnitedHealthcare. No action is required by you to enroll in Empire Plan Medicare Rx and keep your Empire Plan coverage.

If you are Medicare primary, you must be enrolled in Empire Plan Medicare Rx. If you cancel your enrollment in Empire Plan Medicare Rx, your Empire Plan coverage also will be cancelled for Hospital, Medical/Surgical and Mental Health and Substance Abuse benefits.

**Note: Please refer to your Evidence of Coverage and Empire Plan Medicare Rx (PDP) Plus Certificate regarding secondary coverage benefits.**

## 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."

### **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**

UnitedHealthcare 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, UnitedHealthcare 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**

You or another person acting on your behalf may submit an appeal. If a post service claim (a claim for benefits payment after a prescription drug has been dispensed) or a preservice request for benefits is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal in writing to:

The Empire Plan Prescription Drug Program  
UnitedHealthcare  
PO Box 5900  
Kingston, NY 12402-5900

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Prescription Drug Program.

### **Appeal process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If an appeal involves a clinical matter, a Medical Director will be responsible for ensuring the appeal is reviewed by an appropriate Provider who did not previously review the claim or precertification request. If an appeal involves an administrative matter, it will be reviewed by an employee of UnitedHealthcare with problem-solving authority above that of the previous reviewer. By filing an appeal, you consent to this referral and the sharing of pertinent claims information.

### **First level claims review**

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 address shown at the start of this section within 180 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 or comments to support the appeal of the original determination as well as any information that has been requested. A written acknowledgement of your appeal will be sent to you within 15 days after it is received.

For a first level appeal, a review of the appeal will be done and within 30 days of your request, UnitedHealthcare will provide you with a written decision.

If the determination is upheld, UnitedHealthcare's written response will cite the specific Plan provision(s) upon which the denial is based and will include both of the following:

- Detailed reasons for the determination regarding the appeal and the clinical rationale for the determination; and
- Notification of your right to a further review.

### **Second level claims review**

If, as a result of the first level claims review, the original determination of benefits is upheld by UnitedHealthcare, in whole or in part, you can request a second level claims review. This request should be directed either in writing or by telephone to UnitedHealthcare within 60 days after you receive notice of the first level appeal determination. When requesting the second level claims review, you should state the reasons you believe the benefit reduction or denial was improperly upheld and include any information requested by UnitedHealthcare along with any additional data, questions or comments deemed appropriate.

You will receive a written notice stating the results of the second level claims review by UnitedHealthcare within 30 business days from the date all necessary information is received.

If an appeal involves a clinical matter, a Medical Director will be responsible for ensuring the appeal is reviewed by an appropriate Provider who did not previously review the claim or precertification request. If an appeal involves an administrative matter, it will be reviewed by an employee of UnitedHealthcare with problem-solving authority above that of the previous reviewer.

If the determination is upheld, UnitedHealthcare's written response will cite the specific Plan provision(s) upon which the denial is based and will provide detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.

**Appeals involving urgent situations:** If an appeal involves a situation in which your Provider believes a delay would significantly increase the risk to your health or the ability to regain maximum function, or cause severe pain, the appeal will be resolved in no more than 72 hours from receipt of the appeal. Notice of the determination will be made directly to the person filing the appeal (you or the person acting on your behalf).

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Assistance Unit of the New York State Department of Financial Services at: New York State Department of Financial Services, One Commerce Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday through Friday, 9 a.m. to 5 p.m. 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 UnitedHealthcare 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 Financial Services 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 previously and UnitedHealthcare must have upheld the denial or you and UnitedHealthcare must agree in writing to waive any internal appeal.

### **Your right to appeal a determination that a drug 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 previously and, if any new or additional information regarding the prescription drug was presented for consideration, UnitedHealthcare must have upheld the denial or you and UnitedHealthcare must agree in writing to waive any internal appeal.

Your attending physician must certify that you have a condition/disease: 1) whereby standard covered prescription drugs have been ineffective or would be medically inappropriate; or 2) for which there does not exist a more beneficial standard prescription drug covered by the health care plan; or 3) for which there exists a clinical trial or rare disease treatment.

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

- A. 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 physician should contact the New York State Department of Financial Services to obtain current information about what documents will be considered acceptable); 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 condition or disease.

**Your right to appeal that a prescription drug should be covered since you have been diagnosed with what is considered a rare disease** is defined as a condition:

- That is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Network or affects fewer than 200,000 United States residents per year; and
- For which there are no standard prescription drugs covered by the health care plan that are more clinically beneficial than the requested prescription drug.

As part of the external appeal process for rare diseases, a physician other than the member's treating physician must certify in writing that the condition is a rare disease. The certifying physician must be a licensed, board-certified or board-eligible physician specializing in the appropriate area of practice to treat the rare disease. The physician's certification must provide either that:

- The rare disease is or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network; or
- The rare disease affects fewer than 200,000 United States residents per year.

The certification is to rely on medical and scientific evidence to support the requested prescription drug (if such evidence exists) and must include a statement that, based on the physician's credible experience, there is no standard covered prescription drug that will be more clinically beneficial to the member. The statement must also indicate that the requested prescription drug is likely to benefit the member in the treatment of their rare disease and that the benefit outweighs the risks of the prescription drug.

## **The External Appeal Process**

If, through the internal appeal process described previously, 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 four months from receipt of such notice to file a written request for an external appeal. If you and UnitedHealthcare have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. UnitedHealthcare will provide an external appeal application with the final adverse determination issued through UnitedHealthcare's internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services 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 UnitedHealthcare based its denial, the External Appeal Agent will share this information with UnitedHealthcare in order for it to exercise its right to reconsider its decision. If UnitedHealthcare chooses to exercise this right, UnitedHealthcare will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following); UnitedHealthcare 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 UnitedHealthcare. 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 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and UnitedHealthcare 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 UnitedHealthcare's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, UnitedHealthcare will provide coverage subject to the other terms and conditions of the Program.

Please note that if the External Appeal Agent approves coverage of an experimental or investigational prescription drug that is part of a clinical trial, UnitedHealthcare will only cover the costs of the prescription drug required to provide treatment to you according to the design of the trial. UnitedHealthcare shall not be responsible for the costs of investigational devices, the costs of nonhealth-care services, the costs of managing research, or costs that would not be covered under the Policy for nonexperimental or noninvestigational treatments provided in such clinical trial.

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

You will be charged a fee of \$25 for an external appeal, and the annual limit on filing fees for a claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. UnitedHealthcare 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 Financial Services. 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.

### **Four-month External Appeal deadline**

Under New York State law, your completed request for external appeal must be received by the New York State Department of Financial Services within four months (with an additional eight days allowed for mailing) of the date of the Final Notice of Adverse Determination of the first level appeal or the date upon which you receive a written waiver of any internal appeal. UnitedHealthcare 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 271 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.

# Empire Plan Copayments for Employees of the State of New York in APSU who are represented by PBANYS

## 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.ny.gov>.

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)

Non-Hospital Outpatient Surgical Locations  
(including Anesthesiology and same-day  
preoperative testing done at the center) ..... \$30

Medically appropriate professional  
ambulance transportation ..... \$35

\*Copayment waived for preventive services under PPACA. See NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

## 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.ny.gov>.

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-Based Emergency Services

Emergency Room Care ..... \$70\*\*

(The \$70 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 .....	\$60**
Diagnostic Laboratory Tests .....	\$40**
Diagnostic Radiology (including mammography, according to guidelines) .....	\$40**
Administration of Desferal for Cooley's Anemia .....	\$40**
Physical Therapy (following related surgery or hospitalization) .....	\$20
Chemotherapy, Radiation Therapy, Dialysis.....	No copayment
Preadmission Testing/Presurgical 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 The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the MHSA Program before beginning treatment.

Visit to Outpatient Substance Abuse Treatment Program .....	\$20
Visit to Mental Health Professional .....	\$20
Psychiatric Second Opinion when Precertified .....	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 for most Generic Drugs.....	\$5
Level 2, Preferred Drugs or Compound Drugs.....	\$25
Level 3, certain Generic Drugs or Non-Preferred Drugs .....	\$45***

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

Level 1 or for most Generic Drugs.....	\$10
Level 2, Preferred Drugs or Compound Drugs.....	\$50
Level 3, certain Generic Drugs or Non-Preferred Drugs.....	\$90***

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

Level 1 or for most Generic Drugs.....	\$5
Level 2, Preferred Drugs or Compound Drugs.....	\$50
Level 3, certain Generic Drugs or Non-Preferred Drugs.....	\$90***

\*\*\*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.

**Note:** Oral chemotherapy drugs for the treatment of cancer and most Level 1 contraceptives do not require a copayment.