JANUARY 1, 2013 AMENDMENTS

NYSHIP General Information Book and Empire Plan Certificate Amendments

District Council 37

For Employees of the State of New York represented by **District Council 37 (DC-37),** their enrolled Dependents, COBRA Enrollees with their benefits and Young Adult Option Enrollees

Keep these amendments with your July 1, 2003 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

NYSHIP
New York State Health Insurance Program

THE EMPIRE PLAN

TABLE of CONTENTS

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" wherever it appears under "The Empire Plan Benefits Management Program".

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.

EMPIRE PLAN HOSPITAL PROGRAM: CERTIFICATE AMENDMENTS

Network and Non-Network Benefits

Substitute the following for items 1. and 2. in the "Network and Non-Network Benefits" section on page 151 of your September 2005 General Information Book and Empire Plan Certificate Amendments.

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 January 1, 2013, the combined annual coinsurance maximum is $690 for the enrollee, $690 for the enrolled spouse/domestic partner and $690 for all dependent children combined.

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

The $690 coinsurance maximum amounts shall be reduced to $300 per calendar year for employees in or equated to salary level six or below as of January 1, 2013.

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 September 2005 General Information Book and Empire Plan Certificate Amendments.

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.

Skilled Nursing Facility Care

Substitute the following as the first paragraph under "Skilled Nursing Facility Care" on page 226 of your Empire BlueCross BlueShield Certificate amendment in your July 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.

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.

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 "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.*

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 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 January 1, 2013, The Empire Plan combined annual deductible is $322 for the enrollee, $322 for the enrolled spouse/domestic partner and $322 for all dependent children combined.

The combined annual deductible will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I.) for Urban Wage Earners and Clerical Workers, all Cities, (C.P.I.-W) for the period July 1 through June 30 of the preceding year.

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 T. 2. b. "Covered Percentage" under "Meaning of Terms Used" on page 78 of your UnitedHealthcare Certificate.

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 January 1, 2013, the combined annual coinsurance maximum is $690 for the enrollee, $690 for the enrolled spouse/domestic partner and $690 for all dependent children combined.

Each $690 coinsurance maximum shall be reduced to $300 per calendar year for employees in or equated to salary level six or below as of January 1, 2013.

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.

The 20 percent coinsurance you pay for yourself, your enrolled spouse/domestic partner or same-sex spouse and for all dependent children combined for covered services by non-participating providers counts toward your coinsurance maximum. Copayments for services by participating providers also count. (The copayments do not stop when you reach the coinsurance maximum unless The Empire Plan is secondary to another insurance program.)

The annual deductible does not count toward the coinsurance maximum. Any expenses above the reasonable and customary charge or the Scheduled Pharmaceutical Amount do not count. 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 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.

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.

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).

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

F. **Adult Immunizations –** Immunizations for influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chicken pox), and tetanus are covered. Immunization for meningitis is covered for dependent children up to age 26. Immunization for Human Papillomavirus (HPV) is covered for enrollees and dependents age 19 through 26. Immunization for Herpes Zoster (Shingles) is covered for enrollees and dependents age 55 or older. Covered adult immunizations are subject to an office visit copayment.

Substitute the following for item U. under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 82 of your UnitedHealthcare Certificate.

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.

W. **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.

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.

Basic Medical Program

Substitute the following for the first sentence of "A. Annual Deductible" in the "Basic Medical Program" section on page 83 of your UnitedHealthcare Certificate.

See page 319 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.

Substitute the following for the second paragraph of item "B. 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.

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 item under "What is covered under the Basic Medical Program (nonparticipating providers)" on page 85 of your UnitedHealthcare Certificate.

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.

Home Care Advocacy Program (HCAP)

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 90 of your UnitedHealthcare Certificate.

The combined annual deductible applies: See page 319 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 third paragraph of "Deductible and Coinsurance Apply" under "Non-Network benefits" in the "Managed Physical Medicine Program" section on page 92 of your UnitedHealthcare Certificate as amended in your January 2011 Empire Plan Report.

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.

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.

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 in order to obtain current information as to 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 107-130 of your Empire Plan Certificate as amended in your January 2010 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 previously stated requirements and admission is certified by the Mental Health and Substance Abuse Program.

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 that, 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 Abuse 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 $322 for the enrollee, $322 for the enrolled spouse/domestic partner and $322 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 $690 for the enrollee, $690 for the spouse/domestic partner and $690 for all dependent children combined.

The $690 coinsurance maximum amount shall be reduced to $300 per calendar year for employees in or equated to salary level six or below as of January 1, 2013.

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

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 that 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.

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 340 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 "Express Scripts/Medco" for "Medco" except in reference to "Medco Pharmacy" and for "Medco Health Solutions" wherever they appear in "The Empire Plan Prescription Drug Program Certificate" except in the address in the "Non-Network Pharmacies" section on page 250.

Add the following as the first paragraph under "Empire Plan Prescription Drug Program" on page 242 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2009 General Information Book and Empire Plan Certificate Amendments.

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.**

Meaning of Terms Used

Substitute the following definitions on page 244 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2009 General Information Book and Empire Plan Certificate Amendments, as amended in your January 2010 Empire Plan Report.

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.

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.

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.

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.

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.

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.

Prior Authorization Required for Certain Drugs

Substitute the following for the last sentence of the first paragraph of "Prior authorization required for certain drugs" in the "Your Benefits and Responsibilities" section on page 295 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2010 Empire Plan Report.

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

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

Specialty Pharmacy

Substitute the following for the last sentence of the second paragraph in the "Specialty Pharmacy Program" section on page 295 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2010 Empire Plan Report.

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.

Substitute the following for the last sentence of the last paragraph in the "Specialty Pharmacy Program" section on page 295 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2010 Empire Plan Report.

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.

Exclusions and Limitations (Effective January 1, 2013

Substitute the following for item R. in the "Exclusions and Limitations" section on page 296 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2010 Empire Plan Report.

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, Pramosone 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, , Uramaxin GT/Kit, Veltin, Veramyst, Vimovo, Xerese, Xopenex Inhalation Solution, Zegerid capsule, Ziana, Zipsor, Zolpimist, Zolvit, Zuplenz and Zyclara.

Add the following as item S. in the "Exclusions and Limitations" section on page 249 of your January 2009 Empire Plan Certificate and adjust the letters accordingly.

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.

Substitute the following for the fifth paragraph of "Non-Network Pharmacies" in the section titled "How to Use Your Empire Plan Prescription Drug Program" on page 296 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2010 Empire Plan Report.

The Empire Plan Prescription Drug Program
c/o ESI/Medco
PO Box 14711
Lexington, KY 40512

Substitute the following for the "Medicare Prescription Drug Coverage" section on page 254 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2009 General Information Book and Empire Plan Certificate Amendments.

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.

Appeals

Substitute the following for the "Appeals" section on pages 256-258 of your UnitedHealthcare Insurance Company of New York Certificate in your January 2009 General Information Book and Empire Plan Certificate Amendments.

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.