New York State Health Insurance Program

General Information Book and Empire Plan Certificate

Certificate Amendments

For Employees of the State of New York represented by District Council 37

and for their enrolled dependents
and for COBRA enrollees with their benefits

May 2000

State of New York Department of Civil Service Employee Benefits Division


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

Where this document differs from your January 1, 1996 NYSHIP General Information Book and Empire Plan Certificate and later Amendments included in Empire Plan Reports, this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Substitute the following for the last sentence in the second paragraph under “Eligibility for retiree coverage” in the “Continuing Coverage When You Retire or Vest” section on page 16 of your NYSHIP General Information Book.

Do not assume that you are eligible for health insurance benefits in retirement. Also, if you are eligible but do not want your coverage to continue when you retire, you must contact your agency Health Benefits Administrator.

Substitute the following for the fifth paragraph under “Lifetime monthly credit” in the “Continuing Coverage When You Retire or Vest” section on page 18 of your NYSHIP General Information Book.

When you retire, if the dollar value of your sick leave credit amounts to $100 or less, it will be calculated in the same manner as dollar values of $100 or more to provide a lifetime monthly amount of no less than $.01 per month. Or, you may choose to have a credit of less than $100 applied to monthly premiums until the amount runs out. Then, you will contribute the usual enrollee share. Before you retire, you must notify the Employee Benefits Division in writing if you want to use this runout sick leave method.

Substitute the following for the third paragraph under “Deferred Health Insurance Coverage” on page 19 of your NYSHIP General Information Book.

If you die while you are in deferred coverage status, your spouse and any eligible dependents must write to the Employee Benefits Division within 90 days. Eligibility requirements for your spouse and eligible dependents to transfer back to NYSHIP are the same as if you had continued your coverage into retirement. If you choose Dual Annuitant sick leave credit at the time of retirement and die while in deferred status, your eligible surviving spouse will retain the 70 percent sick leave credit. The amount will be calculated based on your age at the time of death.

Substitute the following for “Choice of option” in the “COBRA: Continuation of Coverage” section on page 24 of your NYSHIP General Information Book as amended in your January 1997 Empire Plan Report.

An employee, spouse/domestic partner or dependent child who continues coverage under COBRA will continue in the same plan in which you are enrolled. A COBRA enrollee may change to a different option during the annual Option Transfer Period or when moving under the circumstances described on page 2.

When two or more persons (enrollee, spouse/domestic partner, children) covered under the same Family contract seek COBRA coverage as a result of the same qualifying event, they must continue Family coverage; they may not elect Individual COBRA coverages, unless both spouses/domestic
partners are State employees, until the next Option Transfer Period.
Beginning with the Option Transfer Period in 2000, and in each subsequent
Option Transfer Period, each COBRA beneficiary may elect to change to
Individual coverage in a different plan from that of the family unit.

Add the following to the first paragraph under “60-day deadline” in the “COBRA:
Continuation of Coverage” section on page 25 of your NYSHIP General Information Book.
Other people acting on your behalf may provide written notice to the
Employee Benefits Division of a COBRA-qualifying event.

Substitute the following for the second paragraph under “60-day deadline” in the
“COBRA: Continuation of Coverage” section on page 25 of your NYSHIP General
Information Book.
If the Employee Benefits Division does not receive notice in writing within
that 60-day period, regardless of the reason, the enrollee or dependent will
not be entitled to choose continuation coverage. Your employing agency is
responsible for notifying the Employee Benefits Division of a reduction in
your hours or termination of your employment.

Substitute the following for the fifth paragraph under “60-day deadline” in the
“COBRA: Continuation of Coverage” section on page 25 of your NYSHIP General
Information Book.
If you or your eligible dependent, or someone else acting on your behalf, does
not choose continuation coverage, NYSHIP insurance coverage will end.

Add the following sentence at the end of “Your costs under COBRA” in the “COBRA:
Continuation of Coverage” section on page 25 of your NYSHIP General Information Book.
Payment is considered made on the date of the postmark.

Delete “Conversion: Mental health and substance abuse coverage” in the “Changing
from NYSHIP to Direct-Pay Conversion Contracts” section on page 27 of your NYSHIP

Substitute the following for “How to request direct-pay conversion contracts” in the
“Changing from NYSHIP to Direct-Pay Conversion Contracts” section on page 27 of
your NYSHIP General Information Book as amended in your August 1999 Empire
Plan Reports.

Blue Cross: To request a conversion policy, dependents should call or write
to: Empire Blue Cross and Blue Shield, P.O. Box 11800, Albany, New York
12211-0800; 518-367-0025; 1-800-261-5962.

United HealthCare: To request a conversion policy for medical/surgical
coverage, write to: United HealthCare, P.O. Box 1600, Kingston,
New York 12402-1600.
BLUE CROSS® CERTIFICATE OF INSURANCE

Substitute the following for “8. Intravenous Chemotherapy” in the “Outpatient Hospital Care” section on page 44 of your Blue Cross Certificate.

8. **Chemotherapy.** Blue Cross pays for chemotherapy. The treatment must be ordered by your doctor. Intravenous chemotherapy, oral chemotherapy, subcutaneous injections and intramuscular injections are covered by Blue Cross only if the outpatient hospital setting is medically necessary.

Add the following at the end of “2. Care must be medically necessary” under “Limitations and Exclusions” in the “Blue Cross General Provisions” section on page 48 of your Blue Cross Certificate.

However, if an External Appeal Agent, in accordance with the external appeal provisions under **Filing an Appeal** on page 57, overturns Blue Cross’ determination that care was medically unnecessary, then Blue Cross will cover the hospitalization or related expense to the extent that the hospitalization or related expense is otherwise covered under this Certificate.


Experimental/Investigational procedures shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under **Filing an Appeal** on page 57. If the External Appeal Agent approves coverage of an Experimental or Investigational procedure, only the costs of services required to provide the procedure to you according to the design of the clinical trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

Substitute the following for the first bullet under “2.” in the “Filing and Payment of Blue Cross Claims” section on page 55 of your Blue Cross Certificate.

If the hospital does not deal directly with its local Blue Cross plan:

- For services in the United States, except within New York State, the bill is payable to the hospital unless you have already paid the bill. Then Blue Cross will pay you directly.

Substitute the following for the last sentence of the second paragraph of the third bullet of “2.” in the “Filing and Payment of Blue Cross Claims” section on page 56 of your Blue Cross Certificate.

If the bill is for emergency room medical services, you must also include information about the condition or symptoms that led you to seek emergency room treatment.

Add the following at the end of “Filing and Payment of Blue Cross Claims” on page 56 of your NYSHIP General Information Book.

3. **If Blue Cross denies your claim for benefits.** If Blue Cross denies your claim for benefits for a medical procedure or service on the basis that the medical procedure or service is not medically necessary, benefits will be paid by Blue Cross for covered hospitalization and related expenses if:
• Another Empire Plan carrier has liability for some portion of the expenses for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service; or

• Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written pre-authorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the pre-authorization; and

• You provide to Blue Cross proof of payment or pre-authorization of benefits from the other Empire Plan carrier regarding the availability of Empire Plan benefits to you for that medical procedure or service.

The above provisions will not prevent Blue Cross from imposing any penalties that apply for failure to comply with the Empire Plan Benefits Management requirements. In addition, the above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

Add the following at the end of the “Filing an Appeal” section on page 57 of your Blue Cross Certificate as amended in your March 1999 Empire Plan Report.

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Blue Cross 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 Insurance to conduct such appeals.

If you have been denied coverage on the basis that the service is not medically necessary, you may appeal to 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 Certificate; and

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

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 Certificate; and

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

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

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

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

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service. Only certain documents will be considered in support of this recommendation. Your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable; or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

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

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Blue Cross based its denial, the External Appeal Agent will share this information with Blue Cross in order for it to exercise its right to reconsider its decision. If Blue Cross chooses to exercise this right, Blue Cross will have three business days to amend or confirm its decision.

Please note that in the case of an expedited appeal (described below), Blue Cross 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 Blue Cross. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.
If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and Blue Cross 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 Blue Cross’ decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, Blue Cross will provide coverage subject to the other terms and conditions of the Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Blue Cross will only cover the costs of services required to provide treatment to you according to the design of the trial. Blue Cross shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Certificate for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent’s decision is binding on both you and Blue Cross. The External Appeal Agent’s decision is admissible in any court proceeding.

Blue Cross will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. Blue Cross 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.

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

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

Substitute the following for the first paragraph under “Where to Get More Detailed Information” on page 58 of your Blue Cross Certificate. Also delete the list of local Blue Cross Plans and the counties they serve.

If this book does not answer the questions you may have about your Blue Cross coverage, contact:

   Empire Blue Cross and Blue Shield
   New York State Service Center
   Box 11815
   Albany, New York 12211-0815
   518-367-0009 Albany area and Alaska; 1-800-342-9815 New York State and other states except Alaska
   TTY (Text Telephone) for hearing-impaired or speech-impaired callers: 1-800-241-6894
CERTIFICATE AMENDMENT
for
The Empire Plan

• THIS CERTIFICATE AMENDMENT AFFECTS YOUR RIGHTS AS AN ELIGIBLE ENROLLEE UNDER THE EMPIRE PLAN. PLEASE READ IT CAREFULLY.
• THIS IS TO NOTIFY YOU THAT THE EMPIRE PLAN MEDICAL BENEFITS INSURANCE OBLIGATIONS OF METROPOLITAN LIFE INSURANCE COMPANY, UNDER THE GROUP POLICIES LISTED BELOW, SHALL ON AND AFTER JANUARY 1, 2000 BE TRANSFERRED TO UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK.
• THIS CERTIFICATE AMENDMENT IS ISSUED TO YOU BY UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK. IT IS TO BE ATTACHED TO AND WILL FORM A PART OF YOUR GENERAL INFORMATION BOOK AND EMPIRE PLAN CERTIFICATE.

Group Insurance Policy Numbers: 30500-G, 30501-G and 30502-G, all three collectively referred as the “Group Policies”.


Transfer of Obligations: Effective January 1, 2000, the medical insurance benefits obligations of Metropolitan Life Insurance Company under the Group Policies and all Certificates issued under the Group Policies are transferred to United HealthCare Insurance Company of New York (“United HealthCare”). United HealthCare agrees to pay each eligible enrollee in the Empire Plan the medical insurance benefits described in the Certificates, subject to the provisions and conditions contained in the Certificates.

Name of Insurer: Effective January 1, 2000, if any reference is made in any Certificates to Metropolitan Life Insurance Company (including “Metropolitan” or “MetLife” or any other reference) the reference shall mean “United HealthCare Insurance Company of New York.”

Insurers’ Address: The addresses of the corporate headquarters for the former and succeeding insurers are respectively:

Former Insurer:
Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010

Insurer on and after January 1, 2000:
United HealthCare Insurance Company of New York
2929 Expressway Drive North, Suite 300
Hauppauge, New York 11788

This Certificate Amendment is effective January 1, 2000.

METROPOLITAN LIFE INSURANCE COMPANY

By: ________________
Name: Charles J. Griffith
Title: Vice-President
Date: 2/1/00

219341.1

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

By: ________________
Name: M. Lucie Dassett
Title: Vice President
Date: 2/4/00
Add the following at the end of “Meaning of Terms Used” on page 64 of your United HealthCare Certificate.

AA. An Urgent Care Center is a facility staffed by medical professionals that include physicians and nurses, with evening and weekend hours. It provides services for acute and uncomplicated problems without the need for an appointment.

Substitute the following for the second and third paragraphs under “…when you choose participating providers” in the “Participating Provider Program” section on page 64 of your United HealthCare Certificate.

You pay only your $8 copayment for office visits, surgical procedures performed during an office visit, radiology services, diagnostic laboratory services and visits to an urgent care center when they are covered under the Participating Provider Program. You pay only your $15 copayment for facility charges, including anesthesiology, at a participating ambulatory surgical center. There is no cost to you for some services covered under the Participating Provider Program.

To learn whether a doctor, specialist, laboratory, ambulatory surgical center or urgent care center is an Empire Plan participating provider, check with the provider directly or call United HealthCare at 1-800-942-4640. Or, visit the New York State Department of Civil Service Web site at http://www.cs.state.ny.us. Click on Employee Benefits and Services, then on Empire Plan Participating Provider Directory and follow the instructions.

Substitute the following for the second sentence of the fifth paragraph under “…when you choose participating providers” under “Participating Provider Program” on page 65 of your United HealthCare Certificate.

The Empire Plan does not require that a participating provider refer you to a participating specialist, laboratory, ambulatory surgical center or urgent care center.

Add the following at the end of “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 66 of your United HealthCare Certificate.

Q. **Urgent Care Center** - You are covered for medically necessary visits to and services provided at an Urgent Care Center.

Add the following at the end of “What is covered under the Basic Medical Program (non-participating providers)” in the “Basic Medical Program” section on page 69 of your United HealthCare Certificate.

T. **Urgent Care Center** - You are covered for medically necessary visits to and services provided at an Urgent Care Center.


H. Services deemed Experimental, Investigational or Unproven are not covered under this Plan. However, United HealthCare may deem an Experimental, Investigational or Unproven Service is covered under this Plan for treating a life threatening sickness or condition if:

1) it is determined by United HealthCare that the Experimental, Investigational or Unproven Service at the time of the determination:
   • is proved to be safe with promising efficacy; and
Denial of claim

- 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; or

2) Empire Plan benefits have been paid or approved by Blue Cross for the item or service based on a determination that the service or item is covered under the Empire Plan.

Experimental, Investigational or Unproven Services shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under **Miscellaneous Provisions** on page 84. If the External Appeal Agent approves coverage of an Experimental, Investigational or Unproven treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

*Add the following at the end of “How, When and Where to Submit Claims” section on page 82 of your United HealthCare Certificate.*

If United HealthCare denies your claim for benefits for a medical procedure or service on the basis that the medical procedure or service is not medically necessary, benefits in accordance with Empire Plan provisions will be paid under the Participating Provider or Basic Medical Program for covered expenses if:

- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service; or

- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written pre-authorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the pre-authorization; and

- You provide to United HealthCare proof of payment or pre-authorization of benefits from the other Empire Plan carrier regarding the availability of Empire Plan benefits to you for that medical procedure or service.

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

*Add the following at the end of the “Miscellaneous Provisions” section on page 84 of your United HealthCare Certificate.*

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if United HealthCare 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 Insurance to conduct such appeals.
If you have been denied coverage on the basis that the service is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedure was presented for consideration, United HealthCare must have upheld the denial; or you and United HealthCare must agree in writing to waive any internal appeal.

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

A. The service must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and, if any additional information regarding the adverse determination was presented for consideration, United HealthCare must have upheld the denial; or you and United HealthCare must agree in writing to waive any internal appeal.

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

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

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

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation - your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable); or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.
The External Appeal process

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

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which United HealthCare based its denial, the External Appeal Agent will share this information with United HealthCare in order for it to exercise its right to reconsider its decision. If United HealthCare chooses to exercise this right, United HealthCare will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), United HealthCare 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 United HealthCare. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and United HealthCare 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 United HealthCare’s decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, United HealthCare 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, United HealthCare will only cover the costs of services required to provide treatment to you according to the design of the trial. United HealthCare shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent’s decision is binding on both you and United HealthCare. The External Appeal Agent’s decision is admissible in any court proceeding.
United HealthCare will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. United HealthCare 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.

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

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

EMPIRE PLAN MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

Substitute the following for the Certification on page 85 of your Certificate of Insurance for the Empire Plan Mental Health and Substance Abuse Program.

Certificate of Insurance
Group Health Incorporated
(Herein referred to as GHI)

441 Ninth Avenue
New York, New York 10001

GHI certifies that under and subject to the terms and conditions of Group Policy PLH-5243 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, 1999 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 GHI.

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.

Group Health Incorporated
Form No. PLH-5244
Group Health Incorporated
Certificate of Insurance
Substitute “ValueOptions” for “Value Behavioral Health” or “VBH” wherever either appears in the Certificate for the Mental Health and Substance Abuse Program.

Substitute the following for “United HealthCare Service Corp., P.O. Box 1600, Kingston, New York 12402-1600” wherever it appears in your Certificate for the Mental Health and Substance Abuse Program as amended in your Empire Plan Reports:

ValueOptions
P.O. Box 778
Troy, NY 12181-0778

Substitute the following for the Metropolitan telephone number wherever the telephone number appears in your Certificate for the Mental Health and Substance Abuse Program:

ValueOptions: 1-800-446-3995

Substitute “GHI” for “Metropolitan” or “United HealthCare” wherever either appears in your Certificate for the Mental Health and Substance Abuse Program.

Exceptions to this substitution:

Substitute “ValueOptions” for “Metropolitan” in the fourth paragraph under “NON-NETWORK COVERAGE” on the “Schedule of Benefits for Covered Services,” page 97 of your Certificate for the Mental Health and Substance Abuse Program.

and

Substitute “ValueOptions” for “United HealthCare” in the “How, When and Where to Submit Claims” section on pages 104-105 of your Certificate for the Mental Health and Substance Abuse Program as amended in your Empire Plan Reports.

Additional exceptions are included in Certificate amendments below.

Substitute the following under “Meaning of Key Terms” for “2.” on page 87, “16.” on page 89 and “29.” on page 91 of your Certificate for the Mental Health and Substance Abuse Program.

2. Calendar Year/Annual means a period of 12 months beginning January 1 and ending December 31.

16. GHI means Group Health Incorporated, the insurer for the Empire Plan Mental Health and Substance Abuse Program.

29. Program means the Empire Plan Mental Health and Substance Abuse Program. This Program provides coverage under Group Policy No. PLH-5243 issued to the State of New York, the policyholder, by GHI. This Program replaces coverage for mental health and substance abuse care under Group Policy No. 34450-G issued to the State of New York by Metropolitan Life Insurance Company.

Substitute the following for the first two sentences of the last paragraph of “22.” under “Meaning of Key Terms” on page 90 of your Certificate for the Mental Health and Substance Abuse Program.

The non-network allowance for a service or supply is determined by ValueOptions according to established guidelines. The non-network allowance is used as a basis for determining the amount of Program benefits you are entitled to receive for any service or supply you obtain under the non-network portion of the Program.
Add the following after “28 (d).” under “Meaning of Key Terms” on page 91 of your Certificate for the Mental Health and Substance Abuse Program.

(e) a Registered Nurse Practitioner: a nurse with a Master’s degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided; must be certified and have a practice agreement in effect with a network physician.

Substitute the following for the paragraph under “Release of medical records” in the “How to Receive Benefits...” section on page 94 of your Certificate for the Mental Health and Substance Abuse Program.

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

Substitute the following for the third and fourth paragraphs under “Certification denial and appeal process” in the “Concurrent Review” section on page 95 of your Certificate for the Mental Health and Substance Abuse Program.

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 ValueOptions’ decision. You have 30 days from the date of your receipt of ValueOptions’ written denial notice to request a second level appeal.

Level II clinical appeals are conducted by a panel of two board-certified psychiatrists, one from ValueOptions and one from GHI, and a clinical manager. Panel members have not been involved in the previous determinations in the case. Administrative appeals are reviewed by ValueOptions, in consultation with GHI as needed. A determination will be made within 10 business days of the date ValueOptions received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision.

Add the following at the end of “Outpatient care” in the “What is Covered...” section on page 96 of your Certificate for the Mental Health and Substance Abuse Program.

11. **Home-Based Counseling.** You are covered for home-based care provided by a Network Practitioner. Benefits for these services are available under network coverage only.

12. **Registered Nurse Practitioner.** Services provided by a Registered Nurse Practitioner under the direct supervision of a network physician are covered under the Plan when medically necessary. Services include prescribing medication refills and other services performed within the scope of the Registered Nurse Practitioner’s license in the state where the services are performed. Benefits for these services are available under network coverage only.

13. **Telephone Counseling.** Telephone counseling provided by a network practitioner is covered. Benefits for these services are available under network coverage only.
Add the following as the seventh bullet in item “c” under “Network Coverage” in the “Schedule of Benefits” section on page 97 of your Certificate for the Mental Health and Substance Abuse Program.

- No copayment is required for home-based counseling when provided in place of inpatient care.

Substitute the following for “6.” under “Exclusions and Limitations” on page 99 of your Certificate for the Mental Health and Substance Abuse Program as amended in your March 1998 Empire Plan Report.

6. Services deemed Experimental, Investigational or Unproven are not covered under this Plan. However, ValueOptions and GHI may deem an Experimental, Investigational or Unproven Service is covered under this Plan for treating a life-threatening sickness or condition if they determine that the Experimental, Investigational or Unproven 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.

Experimental, Investigational or Unproven Services shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under Miscellaneous Provisions on page 107. If the External Appeal Agent approves coverage of an Experimental, Investigational or Unproven treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

Substitute the following for “11.” under “Exclusions and Limitations” on page 99 of your Certificate for the Mental Health and Substance Abuse Program.

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.

Delete the sidehead “Division of responsibilities” and the first paragraph under the heading “General Provisions” on page 100 of your Certificate for the Mental Health and Substance Abuse Program. Substitute the following for the second paragraph under “General Provisions” on page 100 of your Certificate for the Mental Health and Substance Abuse Program.

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

Substitute the following for “8.” under “Coordination of Benefits” in the “General Provisions” section on page 102 of your Certificate or the Mental Health and Substance Abuse Program.

8. 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 GHI’s discretion, future benefits may be offset by this amount. In most cases, this will be the amount paid by the other plan.

Substitute the following for “2. Non-network coverage” under “Claim payment for covered services” in the “Claims” section on page 104 of your Certificate for the Mental Health and Substance Abuse Program.

2. **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 ValueOptions for services rendered under non-network coverage in order to receive reimbursement. GHI pays you the non-network allowance for the covered service you obtained. You are always required to pay the inpatient and/or outpatient deductible and the amount billed to you in excess of the non-network allowance. Also, you are ultimately responsible for paying your provider any amount not paid by GHI. However, GHI will pay the non-network allowance directly to an approved facility in lieu of paying you.

Substitute the following for the last sentence in “3. Assignment Prohibited” under “Claim payment for covered services” in the “Claims” section on page 104 of your Certificate for the Mental Health and Substance Abuse Program.

Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, GHI or ValueOptions.

Substitute the following for the paragraph under “Verification of claims information” in the “How, When and Where to Submit Claims” section on page 105 of your Certificate for the Mental Health and Substance Abuse Program.

ValueOptions and GHI have the right to request from approved facilities, practitioners and other providers any information necessary for the proper handling of claims. This information is kept confidential.

Substitute the following for the two paragraphs under “Questions” in the “How, When and Where to Submit Claims” section on page 105 of your Certificate for the Mental Health and Substance Abuse Program.

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call ValueOptions at the following toll-free number: 1-800-446-3995.

Delete “Right to Convert;” from the section heading “Right to Convert: COBRA” and delete the first paragraph “Right to convert to an individual policy” from this section on page 106 of your Certificate for the Mental Health and Substance Abuse Program.

Substitute the following for “Confined on effective date of coverage” under “Miscellaneous Provisions” on page 106 of your Certificate or the Mental Health and Substance Abuse Program.

- **Enrollees with Empire Plan Coverage in Effect Prior to January 1, 1999**

If prior to January 1, 1999, when this GHI Policy took effect, you were enrolled in the Empire Plan and confined in a hospital or similar facility for care or treatment or were confined at home under a practitioner’s care for mental health/substance abuse treatment, and you continue to be confined as of January 1, 1999, your Empire Plan mental health/substance abuse benefits continue under the provisions of the Metropolitan Policy in effect on December 31, 1998, until the date you are no longer so confined or July 1, 2000, whichever is earlier. Your
benefits under this GHI Policy will begin the day after mental health/substance abuse benefits under the Metropolitan Policy end.

- **Enrollees with Empire Plan Coverage in Effect On or After January 1, 1999**

If on or after January 1, 1999, the date you become eligible for coverage under the Empire Plan, you are confined in a hospital or similar facility or are confined at home under a practitioner’s care for mental health/substance abuse treatment, the effective date of your coverage under this Program will be deferred until the date you are no longer confined.

There is, however, an exception to this provision. This Program will pay benefits if you were so confined on the initial coverage date of the group of employees to which you belong. However, benefits are payable only to the extent that they exceed or are not payable through a former health insurance plan. When you are no longer confined, full Empire Plan benefits will apply to you.

Insert the following at the end of “Appeals” in the “Miscellaneous Provisions” section on page 107 of your Certificate for the Mental Health and Substance Abuse Program.

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if GHI 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 Insurance to conduct such appeals.

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

A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedure was presented for consideration, GHI must have upheld the denial; or you and GHI must agree in writing to waive any internal appeal.

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

A. The service must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and, if any additional information regarding the adverse determination was presented for consideration, GHI must have upheld the denial; or you and GHI must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.
Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial (as defined by law).

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

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation - your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable); or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

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

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which GHI based its denial, the External Appeal Agent will share this information with GHI in order for it to exercise its right to reconsider its decision. If GHI chooses to exercise this right, GHI will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), GHI 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 GHI. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must...
Agent must try to notify you and GHI 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 GHI’s decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, GHI 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, GHI will only cover the costs of services required to provide treatment to you according to the design of the trial. GHI shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent’s decision is binding on both you and GHI. The External Appeal Agent’s decision is admissible in any court proceeding. GHI will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. GHI 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.

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

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from GHI that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. GHI has no authority to grant an extension of this deadline.
Empire Plan’s Benefits Management Program ........................................1-800-992-1213

• You must call before a maternity or scheduled hospital admission.
• You must call within 48 hours after an emergency or urgent hospital admission.
• You must call before having an elective (scheduled) Magnetic Resonance Imaging (MRI).

If you do not follow the Benefits Management Program requirements, you will pay a higher share of the costs.

ValueOptions (administrator for GHI)..................................................1-800-446-3995

You must call ValueOptions before beginning any treatment for mental health or substance abuse, including alcoholism. If you do not follow ValueOptions requirements, you will receive a significantly lower level of benefits. In a life-threatening situation, go to the emergency room. Call within 48 hours.

Empire Blue Cross and Blue Shield..................................................518-367-0009 (Albany area and Alaska)
1-800-342-9815 (NYS and other states except Alaska)

New York State Service Center, 11 Corporate Woods Blvd., Albany, NY 12211
Call for information regarding hospital and related services.

United HealthCare Insurance Company of New York ..........................1-800-942-4640
P.O. Box 1600, Kingston, NY 12402-1600
Call for information on benefits under Basic Medical and Participating Provider Programs, predetermination of benefits, claims and participating providers.

Home Care Advocacy Program (HCAP)...........................................1-800-638-9918

You must call to arrange for paid-in-full home care services and/or durable medical equipment/supplies. If you do not follow HCAP requirements, you will receive a significantly lower level of benefits.

Managed Physical Medicine Program/MPN.....................................1-800-942-4640

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

TTY (Text Telephone) lines for hearing-impaired or speech-impaired callers with TTY devices:

Benjamin Management Program....................................................TTY only: 1-800-962-2208
ValueOptions ..........................................................TTY only: 1-800-334-1897
Empire Blue Cross and Blue Shield .................................................TTY only: 1-800-241-6894
United HealthCare ..........................................................TTY only: 1-888-697-9054
Check our newly-designed New York State Department of Civil Service Employee Benefits Division Web site at http://www.cs.state.ny.us.

Click on Employee Benefits and Services for timely information about your Empire Plan benefits.