NEW YORK STATE | The Empire Plan

Empire Plan Certificate Amendments

Management/Confidential; Legislature

For Management/Confidential (M/C) employees of the State of New York or the Legislature, their enrolled dependents, COBRA enrollees and Young Adult Option enrollees

This document describes changes made to the January 1, 2014, Empire Plan Certificate.

June 1, 2019

New York State Department of Civil Service
Employee Benefits Division
www.cs.ny.gov/employee-benefits

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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 unrepresented 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.

Important Note: *Except where noted, the benefits described in this document are effective as of* ***January 1, 2018****. Your Copayments, Combined Annual Deductible, Combined Annual Coinsurance Maximum and Annual Out-of-Pocket Maximum are effective as of* ***June 1, 2019****.*

Effective January 1, 2016*, throughout your* Empire Plan Certificate*, replace all instances of "*reasonable and customary amount*" with "*usual and customary rate.*"*

Throughout your Empire Plan Certificate*, replace all instances of "*emergency room*" with "*emergency department.*"*

Introduction

Add the following new section to the end of the **Introduction***:*

Combined Out-of-Pocket Limits

As a result of federal PPACA provisions, there is a limit on the amount you will pay out of pocket for in-network services/supplies during the Plan year.

In-Network Out-of-Pocket Limit

The out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,150 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- $2,750 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Family Coverage

- $10,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- $5,500 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Out-of-Network Combined Annual Deductible

The combined annual deductible is $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a combined annual deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

The combined annual deductible must be met before Basic Medical Program expenses, non-network expenses under the Home Care Advocacy Program and outpatient non-network expenses under the Mental Health and Substance Abuse Program will be considered for reimbursement.

Combined Annual Coinsurance Maximum

The combined annual coinsurance maximum is $3,750 for the enrollee and $3,750 for the enrolled spouse/domestic partner. All dependent children have a combined annual coinsurance maximum of $3,750.

Each $3,750 coinsurance maximum will be reduced to $1,875 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

Coinsurance amounts incurred for non-network Hospital coverage, Basic Medical Program coverage and non-network Mental Health and Substance Abuse coverage count toward the combined annual coinsurance maximum.

Copayments to Medical/Surgical Program participating providers and to Mental Health and Substance Abuse Program network practitioners also count toward the combined annual coinsurance maximum. (**Note:** Copayments made to network facilities do not count toward the combined annual coinsurance maximum.)

Empire Plan Benefits Management Program

The following amendments apply to Plan documents for the Empire Plan Benefits Management Program.

Hospital, Skilled Nursing Facility and Medical Benefits Management Program

Applies when The Empire Plan is primary

Rename this section **When to use the Benefits Management Program**.

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

A. Preadmission certification for hospital admission

Preadmission certification for skilled nursing facility admission

Add the following to the end of the third paragraph:

Exception: Skilled nursing benefits are available if the enrollee is actively working and Medicare entitlement for the enrollee or one of his or her enrolled dependents is due to end-stage renal disease (ESRD).

E. Medical case management

Voluntary specialist consultant evaluation

Delete the second-to-last sentence in the first paragraph: After you determine which of these doctors you prefer to see, the Benefits Management Program will arrange for the specialist consultant evaluation.

More About the Benefits Management Program

Call again

Effective July 1, 2008, *In the paragraph regarding postponement of magnetic resonance imaging, etc., change the time frame noted from* "six months" *to* "45 days."

Empire Plan Hospital Program

The following amendments apply to Plan documents for the Empire Plan Hospital Program.

Benefits Management Program

Hospital admission

Replace the first six paragraphs of this section (up to **Emergency Admissions***) with the following:*

If You do not follow the provisions of the Benefits Management Program, the Hospital Program Administrator will still review Your claim and will apply penalties and copayments, as applicable.

- You did not call the Benefits Management Program for preadmission certification of an elective (scheduled) inpatient admission or an admission for the birth of a child.
  - If the hospitalization is determined to be medically necessary, a $200 penalty will apply.
  - If the hospitalization is determined to be not medically necessary, You will be responsible for the entire cost of care.
- You did not call the Benefits Management Program within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission.
  - If the hospitalization is determined to be medically necessary, a $200 penalty will apply.
  - If the hospitalization is determined to be not medically necessary, You will be responsible for the entire cost of care.
- You called the Benefits Management Program but did not receive certification for Your admission, or only received certification for part of Your inpatient stay, and You are admitted to the hospital as an inpatient, You will be responsible for the cost of care for each day it was determined that Your hospitalization was not medically necessary.

You may appeal the penalty imposed for failure to call within 48 hours, if You did not call within the required 48 hours after an emergency or urgent hospital admission due to circumstances beyond Your control (for example, due to Your illness), but did call as soon as reasonably possible.

If it is determined that You followed the procedures for emergency or urgent admission when You should have followed the preadmission certification procedures for an elective (scheduled) admission or admission for the birth of a child, a $200 penalty will apply. You will be responsible for all charges for each day on which it was not medically necessary for You to be an inpatient.

Skilled nursing facility admission

Add the following to the end of the paragraph:

Exception: Skilled nursing benefits are available if the enrollee is actively working and Medicare entitlement for the enrollee or one of his or her enrolled dependents is due to end-stage renal disease (ESRD).

Network and Non-Network Benefits

Replace item A. under the **Network Benefits** *bullet with the following:*

Any applicable hospital outpatient copayments. Hospital emergency department visits are subject to a $100 copayment, outpatient surgical expenses are subject to a $95 copayment, diagnostic outpatient services (diagnostic radiology, including mammography, and diagnostic laboratory tests) are subject to a $50 copayment and physical therapy services are subject to a $25 copayment and

Replace the second and third paragraphs after the **Non-Network Benefits** *bullet with the following:*

The combined annual coinsurance maximum is $3,750 for the enrollee and $3,750 for the enrolled spouse/domestic partner. All dependent children have a combined annual coinsurance maximum of $3,750.

Each $3,750 coinsurance maximum will be reduced to $1,875 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

Inpatient Hospital Care

Replace item P. under **Hospital Services Covered** *with the following:*

P. Ambulance service when the ambulance service is owned, operated and billed by the admitting or transferring hospital. For information regarding ambulance providers that are not owned, operated and billed by a hospital, call the Medical/Surgical Program (see *Contact Information*, page 146).

Outpatient Hospital Care

Replace the final paragraph of the bulleted item regarding **Physical Therapy** *with the following:*

You pay a $25 copayment for each visit to the outpatient department of a Network Hospital or the greater of 10 percent of charges or $75 at a Non-Network Hospital for physical therapy when covered by the Hospital Program. This payment is in addition to any other payment, either copayment or coinsurance, applied to outpatient services rendered on the same day.

Replace the bullet regarding **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** *with the following:*

- **Effective January 1, 2017, Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** Coverage is available under these conditions:

  A. A single baseline mammogram for covered persons ages 35 through 39 years, inclusive.

  B. An annual mammogram for covered persons age 40 years and older.

  C. As recommended by Your physician if You are of any age and have a history of breast cancer or a first-degree relative has a history of breast cancer (a first-degree relative is one's biological parent, sibling or child). However, in no event will more than one preventive screening per year be covered.

  Mammograms for the screening of breast cancer are not subject to copayment when provided by a participating provider. When provided by a nonparticipating provider, they are subject to coinsurance.

  Diagnostic mammograms (mammograms that are performed in connection with a diagnosis of breast cancer) are unlimited and are covered when medically necessary. Diagnostic mammograms are not subject to copayment when provided by a participating provider.

  Additional screening and diagnostic imaging, including breast ultrasounds, magnetic resonance imaging (MRI), and, **effective February 20, 2017**, 3-D mammograms (breast tomosynthesis) are covered. Screening and diagnostic imaging for the detection of breast cancer are not subject to copayment when provided by a participating provider. When provided by a nonparticipating provider, they are subject to coinsurance.

Delete the bullet regarding Administration of Desferal for Treatment of Cooley's Anemia.

Add the following before **Copayment for emergency care***:*

- **Hospital Extension Clinic.** Hospitals charge facility fees for outpatient services performed by employed physicians who work in hospital extension clinics. When You see a physician or receive services at a hospital extension clinic, You are being treated at a hospital-owned facility, even if the clinic is located miles away from the main hospital campus.

  Hospital billing policies are not always apparent regarding hospital-owned extension clinics. Professional services and facility fees can be billed separately. If services are billed separately, You can be responsible for a Medical/Surgical Program (professional services) copayment, a facility fee copayment, or the full amount of a facility fee charge. When a facility fee is associated with a service covered under the Hospital Program (such as a non-routine outpatient lab or an outpatient radiology charge), You will be responsible for a $50 copayment. However, if a facility fee is billed without another Hospital Program covered service (e.g., an office visit only or preventive screening only),

You may be responsible for paying the facility fee. When making an appointment, it is Your responsibility to ask the physician's office if a separate facility fee will be charged for Your visit.

- **Urgent Care.** Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Service must be rendered by a provider that has been identified by the Hospital Program as hospital-based. Refer to "Find a Provider" on NYSHIP Online (see *Contact Information*, page 146) for a list of identified hospital-based providers. Urgent care may also be rendered in a physician's office or urgent care center. An urgent care center is a licensed facility (other than a hospital) that provides urgent care. See *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance* for more information regarding coverage for services rendered in a physician's office or urgent care center.
- **Observation Care.** Observation services are hospital outpatient services provided to help a physician decide whether to admit or discharge You following surgery performed in the outpatient department of the hospital or during an emergency department visit. These services include the use of a bed or periodic monitoring by nursing or other licensed staff. If associated with surgery, the outpatient surgery copayment will apply. If associated with an emergency department visit, the emergency department copayment will apply.

Copayment for emergency care

Replace the first sentence of this section with the following:

You must pay the first $100 in charges (copayment) for emergency care in a hospital emergency department.

Copayment for outpatient hospital services

Replace this section with the following:

Except as noted, You must pay the first $95 copayment for outpatient surgical expenses and the first $50 copayment for one or more of the diagnostic outpatient services, listed as follows, for each visit to a Network Facility or the greater of 10 percent of charges or $75 at a Non-Network Facility. Hospitals may require payment of this charge at the time of service.

Hospital outpatient services include:

- Diagnostic radiology, including mammography, according to the above guidelines.
- Diagnostic laboratory tests.

One copayment ($95 if surgery is included or $50 if it is not) covers the outpatient facility and will apply for all covered hospital outpatient services. If multiple services, such as surgery, diagnostic radiology and diagnostic laboratory, are performed during the same outpatient hospital visit, the highest copayment will apply. **Exception:** If physical therapy is rendered on the same date of service as other outpatient services, an additional copayment will be charged for the physical therapy services.

When copayments do not apply

You will not have to pay the copayments for:

- Outpatient surgical expenses or hospital outpatient expenses if You are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit You at that time as an inpatient.
- Certain preventive services received at a Network Hospital as required under the Patient Protection and Affordable Care Act (PPACA).
- The following covered hospital outpatient services provided at a Network Facility:
  - Preadmission testing and/or presurgical testing prior to inpatient admission
  - Covered birth control surgeries
  - Chemotherapy

- Radiation therapy
- Dialysis

When the above services are provided at a Non-Network Facility, You must pay the greater of 10 percent of charges or $75, if You have primary coverage through The Empire Plan.

Skilled Nursing Facility Care

Under the first bullet for item A. **Conditions for Skilled Nursing Facility Care***, replace the description of custodial care with the following:*

Custodial care, which is help with transferring, eating, dressing, bathing, toileting and other such related activities, is not covered.

Under the third bullet for item A. **Conditions for Skilled Nursing Facility Care***, add the following as the second-to-last sentence:*

(**Exception:** Skilled nursing benefits are available if the enrollee is actively working and Medicare entitlement for the enrollee or one of his or her enrolled dependents is due to end-stage renal disease [ESRD].)

Replace item B. **Covered Skilled Nursing Facilities** *with the following:*

B. **Covered Skilled Nursing Facilities.** Benefits for covered services are provided if the facility:

- Is accredited as a skilled nursing facility by one or more of the following: The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or The Board of Certification/Accreditation,
- Undergoes or has undergone within the prior 36 months a site visit survey and receives a passing score by a designated independent external entity (DIEE) using that external entity's previously established and the Joint Commissions' Nursing Care Center (NCC)-approved criteria,
- Is certified as a participating skilled nursing facility under Medicare or
- In the absence of the above criteria, meets the following criteria:

  Must have either (1) a unique skill or service or (2) be in a rural location and/or an underserved population not served by other practitioners and meet the following criteria:

  1. Be confirmed to be delivering services in a designated rural area (based on U.S. Census Bureau) or
  2. Must submit a copy of the Medicare or state agency survey report performed within the past 36 months to be retained in the provider's file and
     - Have no deficiencies noted on Medicare or state oversight review that would adversely affect quality of care or patient safety and
     - Have the Medicare or state agency survey approved after individual review to validate compliance with company standards by the Credentials Committee.

  Coverage is subject to the network and non-network level of benefits if You have primary coverage through The Empire Plan.

Hospice Care

Add the following sentence to the end of item A. **Hospice Organizations***:*

Benefits are not subject to the requirements of the Benefits Management Program.

Number of Days of Care

Replace the first sentence with the following:

The Empire Plan Hospital Program will pay up to 365 benefit days of care for each spell of illness. (**Effective June 1, 2019**, Skilled nursing facility care is limited to 120 benefit days of care per spell of illness.)

Replace the second sentence in **Skilled Nursing Facility Care** *with the following:*

For example, 20 days in a skilled nursing facility count as 10 benefit days of care toward the 120-benefit-day limit.

Center of Excellence for Transplants Program

Centers of Excellence

Replace the first bullet with the following:

- BlueCross and BlueShield Association's Blue Distinction Centers for Transplant (BDCT), a national network of transplant providers who have demonstrated quality care, treatment expertise, and, overall, better patient results.

What is covered

Add the following as the third bullet in this section:

- Expenses associated with donors must be submitted to the donor's health insurance plan first before benefits can be considered under The Empire Plan. Documentation from the donor's health insurance plan must be provided. Donor expenses are considered only after a donor is identified and selected as a positive match.

Infertility Benefits

Replace the first two paragraphs with the following:

Effective November 1, 2016, For the purposes of this benefit, infertility is a disease defined by the failure to achieve or maintain a successful pregnancy after 12 months or more of appropriate, timed, unprotected intercourse or therapeutic donor insemination if the woman is under age 35, and after six months if the woman is age 35 or older or has a known infertility factor.

Infertility benefits, including Qualified Procedures (see the following), are subject to the same copayments and deductibles as benefits for other medical conditions under the Hospital Program. Qualified Procedures are subject to a $50,000 lifetime maximum per covered individual.

This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures. For more information about travel, lodging and meal expenses associated with the Infertility Benefits Program, call the Medical/Surgical Program or see *Centers of Excellence Travel Allowance* in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*.

Additional infertility benefits

Before **You must call The Empire Plan and select the Medical/Surgical Program for prior authorization for Qualified Procedures***, add the new section title* **Qualified Procedures**.

Infertility: Exclusions and limitations

Delete the second to last bullet:

- Assisted reproductive technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant.

Centers of Excellence Travel Allowance

Replace the last sentence of the first paragraph with the following:

Once You arrive at Your lodging and need transportation from Your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

Hospital Program General Provisions

Exclusions and limitations

What is not covered

Add the following sentence to the end of item M. **Mental or Nervous Condition or Substance Use, Including Alcoholism***:*

Please refer to *Section IV: The Empire Plan Mental Health and Substance Abuse Program Certificate of Insurance* or call the Mental Health and Substance Abuse Program (see *Contact Information*, page 148) if You have any questions.

Coordination of Benefits (COB)

Which plan pays first

Delete the final bullet under item E.2 and replace the first bullet under item E.2 with the following:

- The benefits of the plan of the parent whose birthday (the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year.

If You Qualify for Medicare

Replace the last sentence in the first paragraph of **Payment of Medicare Claims** *under item A. with the following:*

You will be responsible for applicable Hospital Program copayments.

Replace the first sentence of the second paragraph of **Payment of Medicare Claims** *with the following:*

If the hospital does not deal directly with the Empire Plan Hospital Program Administrator, submit a hospital claim form and the Explanation of Benefits form You received from Medicare to the Empire Plan Hospital Program Administrator.

Delete the third sentence under item E. **End-Stage Renal Disease***, and add a new fourth sentence so the final two sentences of this item read as follows:*

You must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits. If You are not enrolled in Medicare Parts A and B, benefits under this Plan are reduced to the extent that Medicare benefits could be available to You.

Add the following and re-letter the remaining items:

D. **Amyotrophic Lateral Sclerosis (ALS).** For those eligible for Medicare due to ALS (also called Lou Gehrig's disease), Medicare Parts A and B automatically take effect the month in which your Social Security disability insurance benefits begin.

Filing and Payment of Hospital Program Claims

Replace item B. with the following:

B. **If the Hospital Does Not Deal Directly With Its Local BlueCross Plan:**

- For services in the United States, the payment for medically necessary covered services received in a Non-Network Hospital is made directly to You and You are responsible to pay the hospital.
- For services outside of the United States, Empire BlueCross BlueShield will pay You directly, unless You indicate otherwise.

Follow the directions below to file Your claim:

- If You receive inpatient or outpatient services at a nonmember hospital, ask the hospital to file the claim for You.

If the hospital will not file the claim, You should file the claim directly with the local BlueCross plan (the plan in the area where You received services) within 18 months of Your discharge from the hospital or outpatient service. Send the local BlueCross and/or BlueShield plan an itemized bill showing the services rendered, the dates on which those services were received, the diagnosis and Your Empire Plan identification number. See *Contact Information*, page 147, for instructions on where to send the bill. If the bill is for emergency department medical services, You must also include information about the condition or symptoms that led You to seek emergency department treatment.

The Hospital Program Administrator, at its option, will either pay the hospital directly or will reimburse You directly for covered services. The Empire BlueCross BlueShield payment to You is payment in full for covered services, less any applicable copayments or penalties.

- **Hospital Outside of the United States:** Send an original itemized hospital bill in English or with a translation, if possible, a completed International Claim Form and Your Empire Plan identification number to the address listed in the *Contact Information* section, page 147.

  In order to process Your claims according to the guidelines of The Empire Plan, Empire BlueCross BlueShield may require medical records. To expedite the processing of Your claim, You may wish to obtain copies of Your medical records from the hospital when You are discharged. It would be helpful to have these records translated into English, if possible.

  Payment for these services will be calculated based on the rate of exchange (foreign exchange rate) listed in the *Wall Street Journal* effective on the date of discharge.
- If assistance is needed in the claims filing process, contact The Empire Plan and choose the Hospital Program.

Utilization Review Guidelines

Retrospective reviews

Add the following to the end of the paragraph:

If the Program Administrator has all information necessary to make a decision but fails to make a determination within the required time frames, this will be deemed an adverse determination, subject to an internal appeal. If upon internal appeal, the Program Administrator does not make a decision within the required time frames, the adverse determination will be reversed.

Notice of adverse determination

Add the following to the end of the paragraph:

If the Program Administrator provides a notice of adverse determination but does not attempt to consult with Your provider who recommended the service, Your provider may request a reconsideration of the adverse determination.

Add the following new section after **Utilization Review Guidelines***:*

Grievance Procedures

Grievances

The Hospital Program's grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by the Hospital Program. For example, the procedure applies to contractual benefit denials or issues or concerns You have regarding the Hospital Program's administrative policies or access to providers.

Filing a Grievance

You may contact the Hospital Program by writing to the Hospital Program Administrator (see *Contact Information*, page 147) to file a grievance. You may submit an oral grievance in connection with a denial of a covered benefit determination by calling the Hospital Program (see *Contact Information*, page 147). You or Your designee has up to 180 calendar days to file the grievance from when You receive the decision You are asking to have reviewed.

Once the Hospital Program receives Your grievance, the Hospital Program will mail an acknowledgment letter within 15 business days.

The Hospital Program keeps all requests and discussions confidential, and the Hospital Program will take no discriminatory action because of Your issue. The Hospital Program has a process for both standard and expedited grievances, depending on the nature of Your inquiry.

Grievance determination

Qualified personnel will review Your grievance, or, if it is a clinical matter, a licensed, certified or registered health care professional will review. **For an issue relating to a medical necessity or experimental or investigational determination, see the *Utilization Review Guidelines* section, page 37.**

The Hospital Program Administrator will review Your grievance and will notify You of its decision within the following time frames:

Expedited/Urgent Grievances: By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your grievance. Written notice will be provided within 72 hours of receipt of Your grievance.

Preservice Grievances: A preservice grievance is a request regarding a service or treatment that has not yet been provided. You will be notified in writing within 15 calendar days of receipt of Your grievance.

Post-Service Grievances: A post-service grievance is a claim for a service or treatment that has already been provided. You will be notified in writing within 30 calendar days of receipt of Your grievance.

All Other Grievances: Other grievances include all grievances that are not related to a claim or request for a service or treatment. You will be notified in writing within 45 calendar days of receipt of all necessary information.

Second-level Grievance/administrative Appeal

If You are not satisfied with the resolution of Your grievance, You or Your designee may file a second-level grievance/administrative appeal by writing to or calling the Hospital Program Administrator (see *Contact Information*, page 147). Urgent appeals may also be filed by phone. You have up to 60 business days from receipt of the grievance determination to file a second-level grievance/administrative appeal.

Once the Hospital Program receives Your administrative appeal, the program will mail an acknowledgment letter within 15 business days.

One or more qualified personnel at a higher level than the personnel who rendered the previous grievance determination will review, or if it is a clinical matter, a clinical peer reviewer will review. The Hospital Program Administrator will decide the administrative appeal and notify You in writing within the following time frames:

Expedited/Urgent Grievances: The earlier of two business days of receipt of all necessary information or 72 hours of receipt of Your appeal.

Preservice Grievances: A preservice grievance is a request regarding a service or treatment that has not yet been provided. You will be notified within 15 calendar days of receipt of Your appeal.

Post-Service Grievances: A post-service grievance is a claim for a service or treatment that has already been provided. You will be notified within 30 calendar days of receipt of Your appeal.

All Other Grievances: Other grievances include all grievances that are not in relation to a claim or request for a service or treatment. You will be notified within 30 business days of receipt of all necessary information.

Assistance

If You remain dissatisfied with the Hospital Program's Administrator's second-level administrative appeal determination, or at any other time You are dissatisfied, You may contact the New York State Department of Financial Services (see *Contact Information*, page 150).

If You need assistance filing a grievance or administrative appeal, You may also contact the State Independent Consumer Assistance Program (see *Contact Information*, page 150).

Empire Plan Medical/Surgical Program

The following amendments apply to Plan documents for the Empire Plan Medical/Surgical Program.

Plan Overview

Delete the section title **Participating Providers** *and move the content from that section under* **If You choose a Participating Provider**.

If You choose the Basic Medical Program (a Nonparticipating Provider)

Replace this section with the following:

Before Your covered expenses can be reimbursed, You must meet the Combined Annual Deductible. If You have Family coverage, Your enrolled spouse/domestic partner must meet an annual Deductible. All Your enrolled children, combined, must meet an annual Deductible.

The Empire Plan reimburses You 80 percent of the Usual and Customary Rate for Covered Services, supplies and/or Pharmaceutical Products (or the Scheduled Pharmaceutical Amount for Pharmaceutical Products) or the actual billed charges, whichever is less.

You pay the remaining 20 percent (Coinsurance) until the covered individual or dependent children combined have met the Coinsurance maximum. You also pay any charges above the Usual and Customary Rate.

Rename the **Note** *section* **Special Medical/Surgical Programs**.

Meaning of Terms Used

Rename this section **Definitions**.

Add the following definitions and alphabetize all definitions:

A. **Ambulatory Surgical Center** means a Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

C. An **Appeal** is a request for the Medical/Surgical Program Administrator to review a Utilization Review decision or a Grievance again.

D. **Balance Billing** occurs when a Nonparticipating Provider bills You for the difference between the Nonparticipating Provider's charge and the allowed amount. A Participating Provider may not Balance Bill You for Covered Services other than the Copayment (if applicable).

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, after the annual Deductible has been met, for Covered Medical Expenses incurred under the Basic Medical, non-network Hospital and non-network Mental Health and Substance Abuse (MHSA) Programs.

   The Combined Annual Coinsurance Maximum is $3,750 for the enrollee and $3,750 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Coinsurance Maximum of $3,750.

   Each $3,750 coinsurance maximum will be reduced to $1,875 per Calendar Year for employees in or equated to salary grade level six or below as of January 1 of that year.

   Coinsurance amounts incurred under the Basic Medical, non-network Hospital and non-network 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 annual Deductible does not count toward the Combined Annual Coinsurance Maximum. Any expenses above the Usual and Customary Rate or the Scheduled Pharmaceutical Amount do not

count. Copayments made to network Hospital facilities do not count toward the Combined Annual Coinsurance Maximum. Expenses for ambulance services and expenses under the Home Care Advocacy Program (HCAP), Managed Physical Medicine Program and the Benefits Management Program do not count toward the Combined Annual Coinsurance Maximum, nor do any penalties under the Benefits Management Program or HCAP.

Once the Combined Annual Coinsurance Maximum is met, Covered Medical Expenses will be reimbursed at 100 percent of the Usual and Customary Rate or Scheduled Pharmaceutical Amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the Usual and Customary Rate or Scheduled Pharmaceutical Amount and for any penalties under the Benefits Management Program.

K. **Co-Surgery** is when several physicians (usually with different specialties) work together as primary surgeons to perform distinct parts of a procedure.

N. **Custodial Care** means help with transferring, eating, dressing, bathing, toileting and other such related activities. Custodial Care does not include Covered Medical Expenses determined to be Medically Necessary.

O. **Durable Medical Equipment** is medical equipment that is:

- Designed and intended for repeated use,
- Not consumable or disposable,
- Primarily and customarily used to serve a medical purpose,
- Generally not useful to a person in the absence of disease or injury and
- Appropriate for use in the home.

Q. **Exclusions** are health care services that are not covered and not reimbursed.

R. An **External Appeal Agent** is an entity that has been certified by the New York State Department of Financial Services to perform External Appeals in accordance with New York State law.

S. **Facility** means a Hospital, Ambulatory Surgical Center, birthing center, dialysis center, Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law and a Facility certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility).

T. A **Grievance** is a complaint that is communicated to the Medical/Surgical Program Administrator that does not involve Utilization Review determination.

U. **Habilitation Services** are health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

V. **Health Care Professional** means an appropriately licensed, registered or certified Physician, dentist, optometrist, chiropractor, podiatrist, physical therapist, occupational therapist, midwife, speech-language pathologist, audiologist or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this *Certificate*.

AA. A **Home Health Agency** is an organization that is currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

AC. **Hospital Extension Clinic** is defined in the Hospital Program section of this book on page 19.

AD. **Hospital Inpatient Care** means care in a Hospital that requires admission as an inpatient and that usually requires an overnight stay.

AE. **Hospital Outpatient Care** means care in a Hospital that usually does not require an overnight stay.

AI. **Managed Physical Network (MPN) Non-Network Allowance** means the lower of the following:

- The amount You actually paid for a Medically Necessary service covered under MPN.
- 50 percent of the MPN Network Allowance for such service.

The MPN Non-Network Allowance for a service is determined by the Medical/Surgical Program Administrator and is applied according to established guidelines. The Non-Network allowance is used by the Program Administrator as a basis for determining the amount of benefits You are entitled to receive under Non-Network coverage.

AP. **Physician or Physician Services** means health care services a licensed medical Physician (MD [medical doctor] or DO [doctor of osteopathic medicine]) provides or coordinates.

AR. **Predeterminations** are requests that services or treatments be approved before they have been received (also known as preservice claim determinations). See the *Preservice claim determinations* section on page 86 for more information.

AT. **Primary Coverage** takes precedence and considers a claim first, even when the policy holder has another policy that covers the same services.

AW. **Rehabilitation Services** are health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services consist of physical therapy, occupational therapy and speech therapy in an inpatient and/or outpatient setting.

AZ. **Secondary Coverage** refers to an insurance plan that considers a claim after Primary Coverage.

BA. **Specialist** means a Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

BB. **Team Surgery** is when three or more surgeons (with different or the same specialties) work together during an operative session in the management of a specific surgical procedure.

BC. **Telehealth** means a Provider's use of electronic information and communication technologies to deliver Covered Services to You when You and Your Provider are in different locations.

BD. **Urgent Care** is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care.

BE. An **Urgent Care Center** is a licensed Facility other than a Hospital that provides Urgent Care. Urgent Care is typically available after normal business hours, including evenings and weekends.

BG. **Utilization Review** means the review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or clinical trial).

Replace the following re-lettered definitions:

H. **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 (HCAP) expenses and/or non-network Mental Health and Substance Abuse (MHSA) Program expenses before benefits will be paid under these components of the Plan.

The Empire Plan Combined Annual Deductible is $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

The Combined Annual Deductible must be met before Your claims can be reimbursed.

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

J. Your **Copayment** is the first $25 that You are required to pay for certain services by Participating Providers and Managed Physical Network, Inc., (MPN) network Providers, or the first $50 in a participating outpatient surgical location.

L. **Covered Medical Expenses or Covered Services** means the covered charges for covered medical services performed or supplies or Pharmaceutical Products prescribed by a Physician or other Provider, under the terms and conditions of this *Certificate*, except as otherwise provided below. A Covered Medical Expense or Covered Service is incurred on the date the service, supply or Pharmaceutical Product is received by You. In order for a charge to be a Covered Medical Expense or Covered Service, the service, supply or Pharmaceutical Product must be provided by a Provider as defined in item AV. on page 51.

Charges for a service, supply or Pharmaceutical Product from a person or Facility that is not a Provider as defined above are not Covered Medical Expenses or Covered Services.

The fact that a Physician or other Provider recommends that a service, supply or Pharmaceutical Product be provided by a person who is not a Provider does not make the charge for that service, supply or Pharmaceutical Product a Covered Medical Expense or Covered Service, even if the care provided is Medically Necessary. These services, supplies or Pharmaceutical Products must be Medically Necessary as defined in this section. A more detailed description of covered expenses and Exclusions follows.

Covered Medical Expenses or Covered Services are subject to the Medical/Surgical Program's reimbursement policy guidelines. The Medical/Surgical Program Administrator develops these reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Medical/Surgical Program Administrator accepts.

Following evaluation and validation of certain Provider billings (e.g., error, abuse and fraud reviews), the reimbursement policies are applied to Provider billings. The Medical/Surgical Program Administrator shares the applicable reimbursement policies with Participating Providers through its Provider website. Participating Providers may not bill You for the difference between their Schedule of Allowances (as may be modified by the reimbursement policies) and the billed charge. However, Nonparticipating Providers are not subject to this prohibition and they may bill You for any amounts the Medical/Surgical Program Administrator does not pay, including, but not limited to, amounts that are denied because one of the reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of the reimbursement policies for Yourself or to share with Your Nonparticipating Provider by calling Customer Care at the telephone number on Your ID card.

M. **Covered Percentage**

1. Under the Participating Provider Program, the **Covered Percentage** is **100 percent** of the Schedule of Allowances, after Your Copayment.
2. Under the Basic Medical portion of this Plan, the **Covered Percentage** for Covered Medical Expenses is **80 percent** of the Usual and Customary Rate or the Scheduled Pharmaceutical Amount except:
   a. As provided under *Prospective Procedure Review*, page 7; under the *Home Care Advocacy Program (HCAP)*, page 68; under *Guaranteed access* for the *Managed Physical Medicine Program*, page 74; and under *Infertility Benefits*, page 75; and

b. The **Covered Percentage becomes 100 percent** of the Usual and Customary Rate or the Scheduled Pharmaceutical Amount once the Combined Annual Coinsurance Maximum is met.

3. For infertility benefits, expenses are paid the same as for other medical conditions: The Covered Percentage for Basic Medical Program services is 80 percent of the Usual and Customary Rate. Under the Participating Provider Program, the Covered Percentage is 100 percent of scheduled allowances after Your Copayments. However, You have no Copayment at a Center of Excellence for Infertility. Certain benefits are subject to a Lifetime Maximum as indicated in the *Infertility Benefits* section, page 75.

AF. The **Lifetime Maximum** of the Basic Medical portion of this Plan and the Managed Physical Medicine Program is unlimited. The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is $50,000 (including any applicable travel allowance) per covered person under the Empire Plan Hospital and Medical/Surgical Programs.

AJ. **Managed Physical Network (MPN) Non-Network Provider** means a Provider who has not entered into an agreement with Managed Physical Network, Inc., to accept payment in accordance with the MPN Network Allowance under MPN for chiropractic treatment, physical therapy and occupational therapy. You are responsible for paying a Non-Network Provider's charge. To receive reimbursement for such charges, You must file a claim with the Medical/Surgical Program. Payment will be sent directly to You. **The fees charged by an MPN Non-Network Provider may exceed the amount reimbursed by the Medical/Surgical Program Administrator.**

AL. A **Nonparticipating Provider** is one who has **not** entered into an agreement with the Medical/Surgical Program Administrator to accept payment in accordance with the Schedule of Allowances for Covered Medical Expenses under this Plan. You are responsible for paying a Nonparticipating Provider's charges. To receive reimbursement for such charges, You must file a claim with the Program Administrator. Payment will be sent directly to You. **The fees charged by a Nonparticipating Provider may exceed the amount reimbursed by the Program Administrator.**

AN. **Participating Providers** are those eligible Providers who have an agreement in effect with the Medical/Surgical Program Administrator to accept Your Copayment plus payment directly from the Program Administrator, in accordance with The Empire Plan Schedule of Allowances, as payment in full for covered medical services under the Participating Provider Program. Exceptions to payment in full under the Program are detailed in *Section I: The Empire Plan Benefits Management Program* and under *Infertility Benefits*, page 75. A directory of Participating Providers (which includes Provider locations) is available on NYSHIP Online (see *Contact Information*, page 146).

AV. **Provider** means a Physician, Health Care Professional or Facility licensed, registered, certified and accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, Durable Medical Equipment, medical supplies or any other equipment or supplies covered under this *Certificate* that is licensed, registered, certified or accredited as required by state law.

BF. **Usual and Customary Rate** (formerly known as reasonable and customary charge) means the lowest of:

- The actual charge for a service or supply.
- The usual charge by the Physician or other Provider for the same or similar service or supply.
- The usual charge of other Physicians or other Providers in the same or similar geographic area for the same or similar service or supply.

The determination of the Usual and Customary Rate for a service or supply is made by the Medical/Surgical Program Administrator. In making the determination of the Usual and Customary Rate for a service or supply, the Medical/Surgical Program Administrator uses data sources including the benchmarking database maintained by FAIR Health©, a nonprofit organization approved by the State of New York. The Empire Plan generally utilizes FAIR Health© rates at the 90th percentile to determine

the allowable amount. You may estimate out-of-pocket costs for out-of-network services by contacting Your Provider for the amount that will be charged or You may visit www.fairhealthconsumer.org to determine the Usual and Customary Rate for these services in Your geographic area or ZIP code.

You are responsible for any amount billed by a Nonparticipating Provider that exceeds the Usual and Customary charge, in addition to the annual Deductible and Coinsurance amounts.

Delete the definition for Spell of Illness *from the* **Definitions** *section.*

Participating Provider Program

Replace the last paragraph before **Your out-of-pocket expenses are lower when You choose Participating Providers** *with the following:*

Except as noted below, Your Copayment is $25. After You pay any applicable Copayments, charges for these services will be paid directly to the Participating Provider in accordance with the Program's Schedule of Allowances. However, when the allowed amount for a service is less than the Copayment, You are responsible for the lesser amount.

Your out-of-pocket expenses are lower when You choose Participating Providers

Replace the first paragraph with the following:

You pay only Your $25 Copayment(s) for office visits, home visits, surgical procedures performed during an office visit, radiology services, diagnostic laboratory services and visits to a cardiac rehabilitation center, Urgent Care Center or Convenience Care Clinic when they are covered under the Participating Provider Program. Charges for hospital facility fees are not covered under the Medical/Surgical Program; please refer to Hospital Extension Clinic on page 19.

Replace the first sentence of the second paragraph with the following:

You pay only Your $50 Copayment for Facility charges, including anesthesiology, at a **participating outpatient surgical location**.

Add the following new section after **Your out-of-pocket expenses are lower when You choose Participating Providers***:*

Combined out-of-pocket limit

As a result of PPACA provisions, there is a limit on the amount You will pay out of pocket for in-network services/supplies during the Plan year.

In-network out-of-pocket limit

The out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,150 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse (MHSA) Programs.

Family Coverage

- $10,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse (MHSA) Programs.

Finding Participating Providers

Replace the first sentence leading into the bulleted list with the following:

To learn whether a Provider participates in The Empire Plan:

Replace the second paragraph with the following:

The *Directory* also lists Providers in the following areas who are in the UnitedHealthcare Options Preferred Provider Organization (PPO) network. These areas are: Arizona; Connecticut; Florida; Maryland; New Jersey; North Carolina; Pennsylvania; South Carolina; Virginia; Washington, D.C.; West Virginia and the greater Chicago area. Ask Providers in these areas if they are part of the UnitedHealthcare Options PPO network.

Guaranteed access

Replace the first paragraph with the following:

The Empire Plan will guarantee access to network benefits for Covered Services provided by primary care Physicians and Specialists (listed as follows) in New York State or in the counties of Fairfield and Litchfield in Connecticut; Berkshire in Massachusetts; Bergen, Hudson, Middlesex, Passaic, Sussex and Union in New Jersey; Bradford, Erie, McKean, Pike, Potter, Susquehanna, Tioga, Warren and Wayne in Pennsylvania; and Addison, Bennington, Chittenden, Grand Isle and Rutland in Vermont, when You do not have access to a network Provider within a reasonable distance from Your residence (see chart that follows).

What is covered under the Participating Provider Program

Delete the following from this list and alphabetize the remaining items: Adult Immunizations, Contraceptive Drugs and Devices, Mammograms, Pediatric Immunizations.

Replace the following:

B. **Cardiac Rehabilitation Center** – If Your Physician prescribes cardiac rehabilitation, You pay a $25 Copayment for each visit to a freestanding cardiac rehabilitation center that has an agreement in effect with the Medical/Surgical Program on the date of Your visit. You pay a single Copayment for the use of the Facility and services You receive from nurses and Physicians who monitor the Program. There is no Copayment for visits to a Hospital-based cardiac rehabilitation center that has an agreement in effect with the Medical/Surgical Program Administrator on the date of Your visit.

D. **Dental Care** – You are covered for the following limited dental services, subject to Copayment, 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 (TMJ) syndrome for the following conditions that are consistent with the diagnosis of organic pathology of the joint: 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.

J. **In-Hospital Anesthesia** – You are covered for anesthesia services if such services are performed in connection with covered in-Hospital surgery or maternity care. You are not covered if the anesthesia services are administered by Your surgeon, by Your surgeon's assistant or by a Hospital employee.

K. **In-Hospital Physician's or Other Provider's Visits** – You are covered for Physician's or other Provider's visits while an inpatient in a Hospital with no Copayment if such visits are not related to surgery. Benefits for visits related to surgery are included in the scheduled amount for the surgery.

O. **Office and Home Visits** – You are covered for office visits and home visits by a Physician or other Provider 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.

If Your participating Physician or other Provider 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.

There is no Copayment for well-child office visits, including routine pediatric examinations, pediatric immunizations and the cost of oral and injectable substances, according to prevailing clinical guidelines.

There is no Copayment for professional services for allergy immunotherapy or allergy serum when billed by a Participating Provider. If there is an associated office visit, a Copayment will apply.

See *Preventive Care* on page 58.

Q. **Outpatient Surgical Location** – You pay a $50 Copayment for Facility charges at a freestanding outpatient surgical location (also known as an Ambulatory Surgical Center) that has an agreement in effect with the Medical/Surgical Program on the date of Your elective surgery. You pay a single Copayment for anesthesiology, radiology and laboratory tests performed at the outpatient surgical location on the same day as the surgery. You pay an additional $50 Copayment for pre-operative testing performed on a different day from the surgery. Surgeons' charges are billed separately and covered under either the Participating Provider or Basic Medical Program provisions.

U. **Reconstructive Surgery** – You are covered, subject to Copayment, for the services of a Physician or other Provider for the following:

- Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:
  - Birth defect
  - Sickness
  - Accidental injury
- Reconstructive breast surgery following a Medically Necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following the mastectomy).
- Treatment of physical complications of all stages of the mastectomy, including lymphedema.
- Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other Medically Necessary surgery.

V. **Second Opinion for Cancer Diagnosis** – You pay a $25 Copayment for a second medical opinion by an appropriate Specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

Y. **Surgery** – You are covered for the services of a Physician or other Provider for surgery, including post-operative care, whether performed in or out of a Hospital, subject to the appropriate Copayment. There is no separate reimbursement for a Provider's use of an operating room in the Provider's office.

- **Assistant Surgery** – You are covered, when Medically Necessary for Your surgery, for an assistant during a surgical procedure(s), for Providers who are legally licensed by the state in which they practice to act as an assistant for surgery.
- **Co-Surgery/Team Surgery** – You are covered for co-surgeons or Team Surgery when necessary to perform complex procedure(s).

When you use a Participating Provider, you are responsible only for any applicable Copayment(s).

Add the following:

F. **Diagnostic Imaging for the Detection of Breast Cancer** – See *Preventive Care*, page 58, for information regarding benefits for mammography and diagnostic imaging for the detection of breast cancer.

H. **Gender Dysphoria Treatment** – Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments when Medically Necessary. Services related to gender dysphoria treatment that are cosmetic in nature are not covered.

P. **Outpatient Department Services (Services Provided in the Outpatient Department of a Hospital)** – There is no Copayment for covered outpatient services provided in the outpatient department of a Hospital by a Participating Provider.

S. **Pre-Implantation Genetic Testing** – Pre-Implantation Genetic Testing (PGT) is covered for testing or screening of genetic disorders when the fetus is at risk for the inherited disorder and the Medical/Surgical Plan Administrator determines the service to be Medically Necessary.

Z. **Telehealth (Delivery of Services)** – If Your Provider offers Covered Services using Telehealth, You will not be denied Covered Services because they are delivered using Telehealth. Covered Services delivered using Telehealth may be subject to Utilization Review and quality assurance requirements and other terms and conditions of the *Certificate* that are at least as favorable as those requirements for the same service when not delivered using Telehealth.

Add the following new section after the list of **What is covered under the Participating Provider Program***:*

Preventive Care

The Empire Plan Medical/Surgical Program covers the following services as required by the Patient Protection and Affordable Care Act (PPACA). Preventive services are not subject to Copayments when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP). However, Copayments may apply to services provided during the same visit as the preventive services. Additionally, if a preventive service is provided during an office visit and the preventive service is not the primary purpose of the visit, the Copayment that would otherwise apply to the office visit will still apply.

For more information on preventive care services, see *The Empire Plan Preventive Care Coverage Chart* on NYSHIP Online (see *Contact Information*, page 146), or visit www.hhs.gov/healthcare/rights/preventive-care. The Medical/Surgical Program may provide upon request a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF and immunizations recommended by ACIP. The Medical/Surgical Program covers the following:

- **Adult Annual Physical Examinations** – Adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

  Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening.

  You are eligible for a physical examination once every Calendar Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include eye refractions.

  This benefit is not subject to Copayment when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

- **Adult Immunizations** – Adult immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention are covered, not subject to Copayment, when received from a Participating Provider. Covered adult immunizations include influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chickenpox), tetanus immunizations, human papillomavirus (HPV) immunizations (covered for enrollees and dependents

age 19 through 26), meningitis immunizations and herpes zoster (shingles) immunizations (Shingrix® and Zostavax®). **Effective April 1, 2018**, Shingrix® is paid in full for enrollees and dependents age 50 and older. Zostavax is paid in full for enrollees and dependents age 60 or older and is subject to a Copayment for enrollees and dependents age 55 through 59. There is no benefit for vaccines received from an out-of-network Provider.

- **Bone Mineral Density Measurements or Testing** – Bone mineral density measurements or tests and devices approved by the FDA. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Coverage of prescription drugs is subject to the Prescription Drug Program section of this *Certificate*. You will also qualify for coverage of bone mineral density measurements and testing if any of the following apply:
  - You were previously diagnosed as having osteoporosis or having a family history of osteoporosis.
  - You have symptoms or conditions indicative of the presence or significant risk of osteoporosis.
  - You are on a prescribed drug regimen posing a significant risk of osteoporosis.
  - You have lifestyle factors that pose a significant risk of osteoporosis.
  - Your age, gender or other physiological characteristics pose a significant risk for osteoporosis.

  The Program also covers bone mineral density measurements or tests, and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

  This benefit is not subject to Copayment when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services, such as devices.
- **Family Planning and Reproductive Health Services** – When the office visit is solely for the purpose of obtaining a contraceptive (including contraceptive drugs and devices dispensed by the Provider), the visit is covered, not subject to Copayment. The Medical/Surgical Program covers family planning services, which consist of FDA-approved contraceptive methods dispensed by a Health Care Professional, not otherwise covered under *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*, counseling on use of contraceptives and related topics and sterilization procedures for women. Such services are not subject to Copayment when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. Over-the-counter (OTC) family planning supplies, such as condoms and spermicides, are not covered.

  The Medical/Surgical Program also covers vasectomies, subject to Copayment, and services related to the reversal of elective sterilization, which is not classified as a preventive care and is subject to Copayment.
- **Effective January 1, 2017, Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** – You are covered for mammograms under these conditions:
  - One baseline screening mammogram for covered persons 35 through 39 years of age, not subject to Copayment.
  - One screening mammogram annually for covered persons age 40 and over, not subject to Copayment.
  - If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) with a history of breast cancer, the Medical/Surgical Program covers mammograms as recommended by the treating Provider.
  - In no event will more than one preventive screening per covered person per Calendar Year be covered. A preventive screening is not subject to Copayment.

Diagnostic mammograms (mammograms that are performed in connection with a diagnosis of breast cancer) are unlimited and are covered when Medically Necessary. Diagnostic mammograms are not subject to Copayment when provided by a Participating Provider. Coverage includes screening and Medically Necessary diagnostic imaging for the detection of breast cancer, diagnostic mammograms, breast ultrasounds, magnetic resonance imaging (MRIs) and, **effective February 20, 2017**, 3-D mammograms (breast tomosynthesis).

- **Well-Baby and Well-Child Care** – Well-baby and well-child care, which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics (AAP) is covered. The Medical/Surgical Program also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the AAP recommendations of well-child visits referenced above permits one well-child visit per Calendar Year, the Medical/Surgical Program will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to enrollees from birth through age 19 and is not subject to Copayment.
- **Well-Woman Examinations** – Well-woman examinations, which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear are covered. You are also covered for preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. For a list of the covered preventive services, see *The Empire Plan Preventive Care Coverage Chart* on NYSHIP Online (see *Contact Information*, page 146), or visit www.hhs.gov/healthcare/rights/preventive-care. This benefit is not subject to Copayment when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above.

Effective January 1, 2019, Under New York State law, prostate cancer screenings are covered with no Copayment when provided by a Participating Provider. An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for people age 50 and older who are asymptomatic and for people age 40 and older with a family history of prostate cancer or other prostate cancer risk factors is covered. The Program also covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for people having a history of prostate cancer or other prostate cancer risk factors.

Add the following new section after **Preventive Care***:*

Transitional Care

Continuity of care: When Your Provider leaves the network

If You are in an ongoing course of treatment when Your Provider leaves the Participating Provider network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

To continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated allowance that was in effect just prior to the termination of the Program Administrator's relationship with the Provider. The Provider must also agree to provide necessary medical information related to Your care and adhere to the Program Administrator's policies and procedures, including those for assuring quality of care, and for obtaining preauthorization and a treatment plan approved by the Medical/Surgical Program Administrator. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being rendered by a Participating Provider. You will be responsible only for any applicable

in-network cost-sharing. Please note that if the Provider was terminated by the Medical/Surgical Program Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

Transition of care: New course of treatment

If You are in an ongoing course of treatment with a Nonparticipating Provider when Your coverage under this *Certificate* becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Nonparticipating Provider for up to 60 days from the effective date of Your coverage under this *Certificate*. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Nonparticipating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this *Certificate* becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

To continue to receive Covered Services for up to 60 days or through pregnancy, the Nonparticipating Provider must agree to accept as payment the Medical/Surgical Program Administrator's negotiated allowances for such services. The Provider must also agree to provide necessary medical information related to Your care and to adhere to the Program Administrator's policies and procedures, including those for assuring quality of care and for obtaining preauthorization and a treatment plan approved by the Medical/Surgical Program Administrator. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being rendered by a Participating Provider. You will be responsible only for any applicable in-network cost-sharing.

Basic Medical Program

Add the following paragraphs before **Assignment of benefits to a Nonparticipating Provider is not permitted***:*

Unlike Basic Medical Program expenses, for which You are ultimately responsible for up to the total amount billed by a Nonparticipating Provider, when a Provider is a part of the Basic Medical Provider Discount Program, You are only responsible for up to the discounted amount for Covered Services, including applicable Deductible and Coinsurance. The Plan will always apply the lesser allowable amount under the Basic Medical Program or the Basic Medical Provider Discount Program, as described below.

When the Basic Medical Provider Discount Program Allowable Amount is Lesser and the Discount Applies: You will not be billed for charges in excess of the discounted fee when the discounted fee under the Basic Medical Provider Discount Program is less than the Basic Medical Usual and Customary Rate. Under the Basic Medical Provider Discount Program, the Provider will submit claims for You and the Medical/Surgical Program Administrator will pay the Provider directly.

When the Basic Medical Allowable Amount is Lesser and the Basic Medical Benefit Applies: When the Basic Medical Usual and Customary Rate is lower than the Basic Medical Provider Discount Program discounted amount, expenses for Covered Services will be paid directly to You and considered under the Basic Medical Program. You are responsible up to the Provider's total billed amount, including applicable Deductible and Coinsurance (because there is no discount).

Assignment of benefits to a Nonparticipating Provider is not permitted

Replace this section with the following:

You may not assign any monies due under this *Certificate* to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill (see *Miscellaneous Provisions*, page 88, for more information about surprise bills). Assignments will be made to Hospitals and for ambulance services as long as the ambulance service has a contract in effect with the Medical/Surgical Program and to Providers in the Empire Plan Basic Medical Provider Discount Program. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise required by applicable law.

You must meet a Deductible and pay 20 percent Coinsurance when You choose Nonparticipating Providers

Replace the first two paragraphs under A. **Annual Deductible** *with the following:*

The Combined Annual Deductible for Covered Services supplied by Nonparticipating Providers is $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per Calendar Year for employees in or equated to salary grade level six or below as of January 1 of that year.

Add the following new section after **You must meet a Deductible and pay 20 percent Coinsurance when You choose Nonparticipating Providers***:*

How to estimate Nonparticipating Provider costs

You may estimate out-of-pocket costs for out-of-network services by contacting Your Provider for the amount that will be charged or by visiting www.fairhealthconsumer.org* to determine the Usual and Customary Rate for these services in Your geographic area or ZIP code.

* Selecting this link will route You to an external site that is not owned or controlled by the Medical/Surgical Program Administrator.

What is covered under the Basic Medical Program (Nonparticipating Providers)

Add the following first sentence to this section:

The following benefits are subject to Deductible and Coinsurance, unless otherwise stated.

*For individual entries in this section, delete the language "*subject to deductible and coinsurance"*where it appears.*

Replace the following:

A. **Ambulance Service** – 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. Medically Necessary nonemergency transportation is covered if provided by a licensed ambulance service.

   Covered Medical Expenses for ambulance services include the following:

   - Local commercial ambulance charges except for the first $70. These amounts are not subject to Deductible or Coinsurance.
   - When the enrollee has no obligation to pay, donations up to a maximum of $50 for trips of fewer than 50 miles and up to $75 for trips over 50 miles will be reimbursed for voluntary ambulance services. These amounts are not subject to Deductible or Coinsurance.
   - Coverage for air ambulance related to an emergency condition or air ambulance related to non-emergency transportation is provided to the nearest Hospital where Emergency Care can be performed when Your medical condition is such that transportation by land ambulance is not appropriate; Your medical condition requires immediate and rapid ambulance transportation and transportation cannot be provided by land ambulance; and one (1) of the following is met:
     - The point of pick-up is inaccessible by land vehicle; or
     - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

D. **Dental Care** – You are covered for the following limited 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 (TMJ) syndrome 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.

G. **Eye Care Following Cataract Surgery** – The charges for one pair of prescription eyeglasses or contact lenses and one eye examination are Covered Medical Expenses per affected eye per cataract surgery. These benefits are not subject to Deductible and Coinsurance. Charges for tint, convenience or any add-on expenses will not be covered.

J. **Hearing Aids** – Hearing aids, when prescribed by a licensed Provider, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of $1,500 per hearing aid per ear, once every four years. Children age 12 years and younger are eligible to receive a benefit of up to $1,500 per hearing aid per ear, once every two years when it is demonstrated that a covered child's hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child's hearing loss. These benefits are not subject to Deductible or Coinsurance.

M. **Effective January 1, 2017, Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** – You are covered for mammograms for the screening of breast cancer and will not be subject to Deductible or Coinsurance for the following:

- One baseline screening mammogram for covered persons age 35 through 39.
- One screening mammogram annually for covered persons age 40 and older.
- If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) has a history of breast cancer, the Medical/Surgical Program covers mammograms as recommended by the treating Provider.
- In no event will more than one preventive screening per covered person per Calendar Year be covered.

The following are also covered subject to Deductible and Coinsurance (for a paid-in-full benefit, use a Participating Provider):

Diagnostic mammograms (mammograms that are performed in connection with the diagnosis of breast cancer) are unlimited and are covered when Medically Necessary. Coverage includes screening and Medically Necessary diagnostic imaging for the detection of breast cancer, diagnostic mammograms, breast ultrasounds, magnetic resonance imaging (MRIs) and, **effective February 20, 2017**, 3-D mammograms (breast tomosynthesis).

O. **Mastectomy Prostheses** – One single or double mastectomy prosthesis per Calendar Year is covered in full. Any single external mastectomy prosthesis costing $1,000 or more requires prior approval through the Home Care Advocacy Program (HCAP). This benefit is not subject to Deductible or Coinsurance.

P. **Maternity Care** – You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth and for complications of pregnancy. The Medical/Surgical Program Administrator's payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided.

Maternity care may be rendered by a Physician or other Provider such as a licensed or certified midwife. The midwife must be:

- Licensed or certified to practice midwifery and
- Permitted to perform the service under the laws of the state where the services are rendered.

Q. **Miscellaneous Services and Supplies** – When the Hospital, Mental Health and Substance Abuse (MHSA) or Prescription Drug Program Administrators do not cover the following items, the Medical/Surgical Program will cover them when medically necessary:

- Diagnostic laboratory procedures and radiology.
- X-ray or radiation treatments.
- Oxygen and its administration.
- Anesthetics and their administration, except when performed by the surgeon or the surgeon's assistant.
- Blood transfusions, including the cost of blood and blood products; however, such costs will be Covered Medical Expenses only to the extent that there is evidence, satisfactory to the Medical/Surgical Program, that such supplies could not be obtained without cost.
- Chemotherapy.
- Dialysis.
- Speech therapy.
- Contraceptive drugs and devices that require injection, insertion or other Provider intervention when the drugs/devices are dispensed in a Provider's office.

R. **Modified Solid Food Products** – When prescribed by a Physician or other Provider, modified solid food products (MSFPs) are covered up to a total maximum reimbursement of $2,500 per covered person per Calendar Year. This benefit is not subject to Deductible or Coinsurance.

Modified solid food products include:

- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Modified solid food products that are low in protein or that contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.

S. **Nutritional Counseling/Medical Nutritional Therapy** – You are covered when the treatment is Medically Necessary and the Provider is licensed in the state where the service is rendered.

T. **Outpatient Surgical Location** – You are covered for Medically Necessary Facility charges at a freestanding outpatient surgical location (also known as an Ambulatory Surgical Center).

U. **Physicians** – Services of Physicians and other Providers who perform covered medical services are covered.

V. **Podiatrists** – Services of duly licensed podiatrists for the treatment of diseases, injuries and malformation of the foot are covered, except that those treatments or supplies listed in items J. and U. of the *Exclusions and limitations* section under *Medical/Surgical Program General Provisions* (see page 77) are not Covered Medical Expenses.

X. **Prosthesis 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.

Z. **Reconstructive Surgery** – You are covered for reconstructive surgery under the same conditions as the Participating Provider Program.

AB. **Routine Newborn Child Care** – Physician's or other Provider's services are covered for newborn care for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. These benefits are not subject to Deductible or Coinsurance.

AC. **Routine Pediatric Care** – Routine well-child care is covered for children up to age 19. This care consists of routine physical examinations, including vision and hearing screenings, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. Preventive care and screenings are also covered as provided for in the comprehensive guidelines supported by the Health Resources & Services Administration (HRSA) and items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF). If the schedule of well-child visits referenced above permits one well-child visit per Calendar Year, a well-child visit will not be denied if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by the Advisory Committee on Immunization Practices (ACIP) are also covered.

AD. **Second Opinion for Cancer Diagnosis** – Charges for a second medical opinion by an appropriate Specialist in the event of a positive or negative diagnosis of cancer, recurrence of cancer or a recommendation of a course of treatment for cancer are covered in full, minus the $25 Copayment You would normally pay for a visit to a Participating Provider. This benefit is not subject to Deductible.

AF. **Surgery** – You are covered for the services of a Physician or other Provider for surgery, including post-operative care, under the Basic Medical Program when not covered elsewhere by the Plan. There is no separate reimbursement for a Provider's use of an operating room in the Provider's office.

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 Usual and Customary Rate for the most expensive procedure performed. Less expensive procedures shall be reimbursed in an amount at least equal to 50 percent of the Usual and Customary Rate for these secondary procedures. You will be responsible for amounts charged by a Provider in excess of this rate.

- **Assistant Surgery** – You are covered when it is Medically Necessary for Your surgery to have an assistant during a procedure(s) for a Provider who is legally licensed by the state to act as an assistant for surgery.
- **Co-Surgery/Team Surgery** – You are covered when it is Medically Necessary for Your surgery to have Co-Surgery or Team Surgery for certain procedures.

When You use a Participating Provider, You are responsible only for any applicable Copayment(s).

AH. **Urgent Care Center** – You are covered for Medically Necessary visits to and services provided at an Urgent Care Center.

AI. **Voluntary Sterilization** – Charges for voluntary sterilization are Covered Medical Expenses.

Add the following and alphabetize the list:

F. **Emergency Services** – You are covered for Emergency Services that are performed to treat or stabilize Your emergency condition in a Hospital. Covered charges billed separately by the attending emergency department Physician and Providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and/or pathology services, will be paid in full by the Medical/Surgical Program.

Services that are provided by other specialty Physicians or other Providers in a Hospital emergency department are considered under the Participating Provider Program if the Physician participates in The Empire Plan.

If the emergency services are provided by a Nonparticipating Provider, the charges will be considered under the Basic Medical Program. These charges are not subject to Deductible or Coinsurance.

H. **Gender Dysphoria Treatment** – Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments when Medically Necessary. Services related to gender dysphoria treatment that are cosmetic in nature are not covered.

W. **Pre-Implantation Genetic Testing** – Pre-Implantation Genetic Testing (PGT) is covered for testing or screening of genetic disorders when the fetus is at risk for the inherited disorder and the Medical/Surgical Plan Administrator determines the service to be Medically Necessary.

AG. **Telehealth (Delivery of Covered Services)** – If Your Provider offers Covered Services using Telehealth, the Medical/Surgical Program will not deny the Covered Services because they are delivered using Telehealth. Covered Services delivered using Telehealth may be subject to Utilization Review and quality assurance requirements and other terms and conditions of the *Certificate* that are at least as favorable as those requirements for the same service when not delivered using Telehealth.

Add the following new section before **Home Care Advocacy Program (HCAP)***:*

Out-of-Network Referral

New York State law requires The Empire Plan to provide access to primary care and specialty Providers at the in-network level of benefits if these services are not available within a 30-mile radius or 30-minute travel time from Your home address.

This requirement applies to Empire Plan-primary members residing in New York State and those states/regions where the Plan has a UnitedHealthcare PPO Options agreement in effect, including: Connecticut; New Jersey; Pennsylvania; Maryland; North and South Carolina; Florida; Arizona; Washington, D.C.; Virginia; West Virginia; and the Chicago, Illinois, area. If You require access to a certain Provider, contact the appropriate Empire Plan Program Administrator (see *Contact Information*, page 146).

In addition, if The Empire Plan network does not have a Provider accessible to You who has the appropriate level of training and experience to treat a condition, You have the right to request an out-of-network referral to a qualified Provider. You or Your attending Physician must first request approval from the appropriate Plan Administrator to receive consideration for the service to be paid at an in-network level. The attending Physician must recommend the Provider with the qualifications to meet the health care needs of the patient. The attending Physician, not the Provider for whom the out-of-network referral request is being made, must provide this written recommendation on behalf of the patient.

If the Plan approves the request, You must use this approved out-of-network provider and Covered Services will be paid at the in-network benefit level with only the applicable network Copayment owed. You are responsible for contacting the Provider to arrange care. If the Plan denies the request, benefits for Covered Services received from a Nonparticipating Provider are available under out-of-network benefit provisions, subject to Deductible and Coinsurance. You may also request an External Appeal through the NYS Department of Financial Services (see *Contact Information*, page 146).

Home Care Advocacy Program (HCAP)

Replace the first sentence with the following:

The Home Care Advocacy Program (HCAP) is The Empire Plan program for home care services, certain Durable Medical Equipment and medical supplies that are associated with Durable Medical Equipment (see the definition for item A., *Durable Medical Equipment*, page 69).

Network coverage: Paid-in-full benefit

Replace the last sentence before **Important Notes** *with the following:*

For ostomy supplies, call the designated ostomy supply company (see *Contact Information*, page 147). You must provide the network supplier with a copy of the Provider's order for the diabetic or ostomy supplies.

Delete the following from **Important Notes***:*

- **HCAP-Covered Durable Medical Equipment and Supplies** – To be an HCAP-covered expense, the equipment or supplies must be prescribed by Your Physician, be Medically Necessary as determined by HCAP and covered under The Empire Plan.

  In some cases, HCAP will certify certain Durable Medical Equipment or supplies for an extended period, and You won't have to call each time You need that item.

  Refer to *Non-network benefits* for coverage of Durable Medical Equipment when You do not use HCAP.

- **Certain other home health care services and prescription drugs are covered under HCAP only when the home care arranged through HCAP takes the place of hospitalization or care in a skilled nursing facility:**

  A. **Home Health Aides** – Home health aide services consist primarily of caring for the patient in conjunction with skilled nursing services. (The Empire Plan does not cover assistance in activities of daily living, called custodial care.)

  B. **Physical, Occupational and Speech Therapy** – HCAP covers home physical, occupational and speech therapy.

  C. **Prescription Drugs** – Prescription drugs billed by a home care agency certified under Article 36 of the New York State Public Health Law are covered under HCAP if The Empire Plan would have paid for those items if You were in a Hospital or confined in a skilled nursing facility. In all other cases, coverage for prescription drugs dispensed by a licensed pharmacy is under, and subject to, the provisions of Your Prescription Drug Program.

  D. **Laboratory Services** – HCAP covers laboratory services provided by or on behalf of the home care agency.

Coverage ends under HCAP for these services when the home care being provided is no longer taking the place of hospitalization or care in a skilled nursing facility. After HCAP coverage ends, coverage for these services is subject to the provisions of the Participating Provider and Basic Medical Programs. For physical therapy, benefits will be under the Managed Physical Medicine Program.

Add the following new section title before the sentence **The following home care services and/or Durable Medical Equipment or supplies related to Durable Medical Equipment are covered under HCAP when prescribed by Your doctor and determined to be Medically Necessary by the Medical/ Surgical Program Administrator***:*

What is covered

Replace the following:

A. **Durable Medical Equipment (DME)** covered under HCAP includes the rental or purchase of DME when appropriate. You must call HCAP, and HCAP will provide You with the name of an HCAP-approved Provider and/or an authorization when necessary.

   Examples of DME covered under HCAP that may be considered Medically Necessary when prescribed by Your doctor include, but are not limited to: Hospital-type beds, equipment needed to increase mobility (such as a wheelchair), respirators or other equipment for the use of oxygen and monitoring devices. Items not covered under HCAP, such as prosthetics, braces (except cervical collars) and splints, will be considered under the Participating Provider Program or Basic Medical coverage.

Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement. The Medical/Surgical Program Administrator will cover the cost of repair or replacement when made necessary by normal wear and tear. Upgrade or replacement of DME when the existing equipment is still functional is not covered.

The Program Administrator does not cover equipment that does not meet the definition of DME such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment, bath equipment or stair lifts/glides/elevators.

B. **Medical Supplies** covered under HCAP include diabetic supplies, ostomy supplies and supplies that are an integral part of Durable Medical Equipment, such as oxygen tubing, oxygen masks and batteries for power wheelchairs, when the supply is necessary for the effective use of the item/device.

- **Diabetic Supplies** include glucometers, test strips, lancets, alcohol swabs and syringes. If You have insulin-dependent diabetes, You are eligible for HCAP benefits for blood-testing supplies, including a glucometer. If You have non-insulin-dependent diabetes, You may be eligible for blood-testing supplies, including a glucometer. To be considered for benefits, You must be managing Your diabetes under the direction of a Physician, for example, through diet, exercise and/or medication.

D. **Skilled Nursing Services in the Home** – You are covered for Medically Necessary visits by nurses from accredited HCAP participating nursing agencies. Care must be prescribed by, and under the supervision of, a Physician. Inpatient visits will not be considered a covered expense.

The services rendered must be Medically Necessary and must require the skills of nursing care when that care is needed to manage medical problems of acutely ill patients. This does not include assistance with daily living, companionship or any other service that can be given by a less skilled person, such as a home health aide. Skilled nursing services do not include Custodial Care, including, but not limited to, domiciliary care, respite care or rest cures. Skilled nursing services also do not include services provided by personal care attendants, family members or nonprofessional caregivers.

Refer to *Non-network benefits*, page 71, for coverage of skilled nursing services when You do not use HCAP.

Refer to *Section II: The Empire Plan Hospital and Related Expenses Certificate of Coverage*, item Q., page 16, for coverage of a maternity home care visit following early discharge after delivery.

E. **Home Infusion Therapy** – You are covered for infusion therapy, which is the administration of drugs using specialized delivery systems that otherwise would have required You to be hospitalized. The act of administering drugs or nutrients directly into the veins is considered infusion therapy. Drugs taken by mouth or drugs that are self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional. Prescription medications used in therapies, such as chemotherapy and/or pain management, and dispensed by a licensed pharmacy are subject to the provisions of Your prescription drug program (see *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*).

F. **Enteral Formulas** – You are covered for nonprescription enteral formulas for home use under HCAP, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, intellectual disability or death if left untreated. These conditions include, but are not limited to: inherited diseases of amino acid or organic acid metabolism, Crohn's disease, gastroesophageal reflux with failure to thrive, gastroesophageal motility such as chronic intestinal pseudo-obstruction and multiple severe food allergies.

Food thickeners, baby food and other grocery products that can be blenderized and used with the enteral system are not covered.

Examples of formulas not covered are:

- Electrolyte-containing enteral fluids
- Self-blenderized formulas

Add the following after Medical Supplies *under* **What is covered***:*

C. **Communication Devices** – You are covered for a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, the rental or purchase of assistive communication devices is covered when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through typical means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. You are covered only for devices that generally are not useful to a person in the absence of communication impairment. You are not covered for items, such as, but not limited to, a laptop, a desktop or tablet computers. You are covered for software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Program Administrator will determine whether the device should be purchased or rented.

   You are covered for repair, replacement, fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. Coverage will be provided for the device most appropriate to Your current functional level. You are not covered for delivery or service charges or routine maintenance. A carrying case (including shoulder strap or carrying handle of any type) is a convenience item and is not covered.

Non-network benefits

Replace the first two paragraphs of **The Combined Annual Deductible Applies** *with the following:*

The Combined Annual Deductible for Covered Services supplied by Nonparticipating Providers is $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per Calendar Year for employees in or equated to salary grade level six or below as of January 1 of that year.

Managed Physical Medicine Program

Throughout this section, add "occupational therapy" *or* "occupational therapist" *when listing services covered.*

Network benefits

Replace this section with the following:

You pay a $25 Copayment for each office visit for chiropractic treatment, physical therapy or occupational therapy when You choose an MPN network Provider. You pay an additional $25 Copayment for related radiology and diagnostic laboratory services billed by the MPN Network Provider. If an MPN Network Provider bills for radiology and diagnostic laboratory services performed during a single office visit, only one Copayment for both radiology and diagnostic services will apply.

$20 Copayments when You use a Network Provider

Rename this section **$25 Copayments when You use a Network Provider**.

Guaranteed access

Replace the second-to-last sentence with the following:

MPN will make arrangements for You to receive Medically Necessary chiropractic treatment, physical therapy or occupational therapy, and You will pay only Your $25 Copayment for each visit.

Deductible and Coinsurance apply

Replace the second paragraph with the following:

Coinsurance Applies: After satisfying the Managed Physical Medicine Program deductible, You will be reimbursed up to a maximum of 50 percent of the network allowance for covered Medically Necessary services from a non-network Provider.

Infertility Benefits

Replace the first paragraph with the following:

Effective November 1, 2016, For the purposes of this benefit, infertility is a disease defined by the failure to achieve or maintain a successful pregnancy after 12 months or more of appropriate, timed, unprotected intercourse or therapeutic donor insemination if the woman is under age 35, and after six months if the woman is age 35 or older or has a known infertility factor.

Center of Excellence for Infertility

Infertility: Exclusions and Limitations

Delete the following from the list of expenses that are not covered:

- Medical expenses or other charges related to genetic selection.
- Assisted reproductive technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant.

Centers of Excellence Travel Allowance

Replace the last sentence of the first paragraph with the following:

Once You arrive at Your lodging and need transportation from Your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

Replace the last paragraph with the following:

The travel allowance for preauthorized infertility services will be applied toward the $50,000 maximum lifetime benefit for Infertility Benefits.

Medical/Surgical Program General Provisions

Exclusions and limitations

Replace this list to add titles to each of the exclusions and limitations, alphabetize the list, and revise definitions for Claims for Prohibited Referrals; Cosmetic Services; Custodial, Convalescent and Residential Care; Dental Services; Experimental or Investigational Treatment; Food Supplements and Vitamins; Legal Action or Settlements; Medically Necessary; Military Service; No-Fault Automobile Insurance; Vision Services; War; Weight Reduction; *and* Workers' Compensation.

A. **Anesthesia.** Services, supplies or Pharmaceutical Products for the administration of anesthesia if the charges for surgery are not covered under this Plan.

B. **Claims for Prohibited Referrals.** Any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services, X-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

C. **Cosmetic Services.** Cosmetic services, Pharmaceutical Products or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child, which has resulted in a functional defect. You are covered for services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this *Certificate*. Cosmetic surgery does not include surgery determined to be Medically Necessary. Also excluded are services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs. Refer to *What is covered under the Participating Provider Program*, page 55, and *What is covered under the Basic Medical Program (Nonparticipating Providers)*, page 63, for limited coverage of reconstructive surgery.

D. **Custodial, Convalescent and Residential Care.** Services, supplies and Pharmaceutical Products rendered for convalescent care, Custodial Care, long-term care facility care, rest cures, and services, supplies and Pharmaceutical Products rendered in a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home or in an educational facility, except as otherwise specifically covered under this Plan.

E. **Dental Services.** 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 cavities, periodontics (including, but not limited to, gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered.

F. **Effective Date (Services Received Before).** Services, supplies or Pharmaceutical Products that You received before You were covered under this Plan.

G. **Experimental or Investigational Treatment.** Services, supplies or Pharmaceutical Products deemed experimental or investigational are not covered under this Plan. However, the Medical/Surgical Program Administrator may deem an experimental or investigational service is covered under this Plan for treating a life-threatening sickness or condition if:

- It is determined by the Program Administrator that the experimental or investigational service at the time of the determination:
  - Is proved to be safe with promising efficacy,
  - 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.
- Empire Plan benefits have been paid or approved by another Empire Plan Program Administrator for the item or service based on a determination that the service or item is covered under The Empire Plan.
- Approved by an External Appeal Agent in accordance with an External Appeal. For External Appeal provisions, see *External Appeals*, page 95. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, only the costs of services, supplies or Pharmaceutical Products 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 nonhealth-care services or Pharmaceutical Products, the costs of managing research or costs not otherwise covered by The Empire Plan for nonexperimental or noninvestigational treatments provided in connection with such clinical trial.

H. **Family Member Provided Services.** Services, supplies or Pharmaceutical Products provided by Your father, mother, brother, sister, spouse/domestic partner or children.

I. **Food Supplements and Vitamins.** Dietary food supplements or vitamins that are not Covered Medical Expenses. **Exception:** Modified solid food supplements and enteral formulas are covered as described on pages 66 and 70 of this *Certificate*.

J. **Foot Care.** Services, supplies and Pharmaceutical Products, including cutting or removal, for treatment of corns, calluses or toenails, except care that is Medically Necessary due to metabolic disease diagnosed by a doctor.

K. **Government Facility Services.** Services, supplies or Pharmaceutical Products provided in a veterans' facility or other services or Pharmaceutical Products furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under The Empire Plan were not in effect. However, this exclusion will not apply to services, supplies or Pharmaceutical Products 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.

L. **Legal Action or Settlements.** Services, supplies or Pharmaceutical Products for which You receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance plan under an individual policy issued to You, where not prohibited by state and/or federal law.

M. **Maternity Services.** If routine services, supplies or Pharmaceutical Products are provided by both a nurse midwife and doctor, only one Provider will be paid for these services, supplies or Pharmaceutical Products.

N. **Medically Necessary.** Any health care service, procedure, treatment, test, device or Pharmaceutical Product that the Program Administrator determines is not Medically Necessary. If an External Appeal Agent certified by the State overturns the Program Administrator's denial, however, the Program Administrator will cover the service, procedure, treatment, test, device or Pharmaceutical Product for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Pharmaceutical Product is otherwise covered under the terms of this *Certificate*.

O. **Mental Health and Substance Use.** Expenses for mental health or substance use services, supplies and Pharmaceutical Products, including alcoholism. Refer to *Section IV: The Empire Plan Mental Health and Substance Abuse Program Certificate of Insurance* for coverage of these services.

P. **Military Service.** Services, supplies or Pharmaceutical Products received as a result of illness or medical condition due to service in the Armed Forces or auxiliary units.

Q. **No-Charge Services.** Services, supplies or Pharmaceutical Products received by You for which no charge would have been made in the absence of coverage under The Empire Plan.

R. **No-Fault Automobile Insurance.** Services, supplies or Pharmaceutical Products to the extent they are provided for any loss or portion thereof for which mandatory no-fault automobile benefits are recovered or recoverable. This exclusion applies if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

S. **No-Payment-Required Services.** Services, supplies or Pharmaceutical Products for which You are not required to pay.

T. **Noncompliance With Hospital Plan Requirements.** Services, supplies or Pharmaceutical Products to the extent they are not covered by the Hospital Program due to noncompliance with the requirements of The Empire Plan for inpatient admission, the mandatory Prospective Procedure Review or for inpatient diagnostic testing.

U. **Orthopedic Shoes and Other Devices.** 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. However, a Medically Necessary custom-made orthopedic appliance, commonly known as an orthotic device, used to support, align, prevent or correct deformities or to improve the function of the foot, is covered as outlined in the *Participating Provider* and *Basic Medical Program* sections.

V. **Pharmacy-Dispensed Pharmaceutical Products.** Federal legend drugs and insulin dispensed by a licensed pharmacy. Refer to *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance* for coverage of these Pharmaceutical Products.

W. **Records Preparation Fees.** Preparation or copying fees for medical summaries and medical invoices for services and/or pharmaceutical supplies rendered.

X. **Skilled Nursing (Inpatient).** Expenses for skilled nursing services while You are an inpatient.

Y. **Vision Services.** Eyeglasses or contact lenses or exams and eye refractions to prescribe them, except as described in the list of Covered Medical Expenses outlined in the *Basic Medical Program* section, page 63.

Z. **War.** Services, supplies or Pharmaceutical Products received as a result of illness or a medical condition due to an act of war, declared or undeclared.

AA. **Weight Reduction.** Services, supplies or Pharmaceutical Products rendered in conjunction with weight reduction programs, unless treatment is in a Provider's office. **Exception:** Screening and counseling for obesity, diet and nutrition in a primary care setting as required under the Patient Protection and Affordable Care Act (PPACA) as preventive care services received from a Participating Provider are covered expenses.

AB. **Workers' Compensation.** Services, supplies or Pharmaceutical Products provided under any state or federal Workers' Compensation, employer's liability or occupational disease law.

Coordination of Benefits (COB)

*Replace the seventh bullet under the definition of "*Plan*" with the following:*

- Any other plan that covers people as a group, including student health plans.

Delete the final bullet under item E.2 and replace the first bullet under item E.2 with the following:

- The benefits of the plan of the parent whose birthday (the word "birthday" refers only to month and day in a Calendar Year, not the year in which the person was born) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year.

Impact of Medicare on this Plan

Definitions

Add the following definition:

H. **Amyotrophic Lateral Sclerosis (ALS)**, or Lou Gehrig's disease, is a progressive neurodegenerative disease. A person whose disability is ALS will be eligible for Medicare the month in which Social Security disability benefits begin.

Coverage

Replace the first sentence of item B. with the following:

B. **Active Employees and/or Their Dependents** – This Plan will automatically be the primary payor for active enrolled employees, regardless of age, and for the employee's enrolled dependents (except for a domestic partner eligible for Medicare due to age) unless end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS) provisions apply.

Add the following and re-letter the remaining items:

D. **Amyotrophic Lateral Sclerosis (ALS)** – For those eligible for Medicare due to ALS (also called Lou Gehrig's disease), Medicare Parts A and B automatically take effect the month in which Your Social Security disability insurance benefits begin.

Add the following new section before **How, When and Where to Submit Claims***:*

How The Empire Plan calculates benefits when Medicare is Primary

Benefits are calculated using the amounts on the Medicare claim that are the patient's responsibility. Plan Copayments, Deductible and Coinsurance will apply. This includes Copayments for Participating Provider services, Deductible and Coinsurance for Basic Medical services and program-specific benefits for services that fall under the Benefits Management Programs, such as the Managed Physical Network (MPN) and the Home Care Advocacy Program (HCAP). The Medical/Surgical Program Administrator will determine the patient responsibility after Medicare has considered the claim.

Medicare Part B has an annual deductible that must be met before Medicare will make payment for services. After Your claim is processed by Medicare, The Empire Plan considers the balance for Secondary coverage. Benefits are calculated using the amounts on the Medicare claim that are designated as patient responsibility.

Before Empire Plan benefits are paid:

- For Participating Provider services, Copayments will be applied to the patient responsibility.
- For Basic Medical claims, Deductible and Coinsurance will be applied to the patient responsibility.
- For services that fall under the Benefits Management Program (such as MPN and HCAP), the program-specific benefits will be applied to the patient responsibility. Refer to the applicable sections of this *Certificate* (i.e., for HCAP benefits, see the *HCAP* section) for more details.

The Medicare allowed amount will apply toward the Medicare annual deductible until it has been satisfied for the year. If You use a Provider that accepts Medicare and participates in The Empire Plan, You will only be responsible for any applicable Copayments.

How, When and Where to Submit Claims

Where

Replace this section with the following:

Completed claim forms with supporting bills, receipts and, if applicable, the Statement of Payment from the Hospital Program Administrator and/or the Medicare Summary Notice should be sent to the general UnitedHealthcare address listed in the *Contact Information* section, page 146. Or, You may email using UnitedHealthcare's secure email link: https://nyrmo.optummessenger.com/public/opensubmit or fax forms to 845-336-7716.

Claim determinations

Replace the last sentence of the first paragraph with the following:

If You disagree with the Program's claim determination, You may submit a grievance pursuant to the *Grievance Procedures* section, page 92.

Right to Convert to an Individual Policy

Move the final two sentences above An individual policy (direct-pay conversion contract) is not available to enrollees and/or covered dependents who *and add the following paragraph:*

The policy offered to You will not have the same benefits as The Empire Plan. You may also seek coverage (as a result of the Patient Protection and Affordable Care Act [PPACA]) through the Health Insurance Marketplace. Coverage is available nationwide. Visit www.healthcare.gov or www.nystateofhealth.ny.gov for more information.

Miscellaneous Provisions

Add the following new first section under **Miscellaneous Provisions***:*

Protection from Surprise Bills

New York State law protects patients from being responsible for paying the full charge for surprise bills. This law generally applies only to services provided within New York State. Under this law, patients receive in-network benefits for any bill deemed to be a surprise bill.

What is a surprise bill?

When You receive services from a Nonparticipating Health Care Professional, the bill You receive for those services is a surprise bill if:

- You received services at a network Hospital or Ambulatory Surgical Center and a Participating Health Care Professional was not available.
- A Participating Health Care Professional sends a specimen taken from the patient in the office to a Nonparticipating laboratory or pathologist without Your explicit written consent.
- Unforeseen medical circumstances arose at the time the health care services were provided.
- A Nonparticipating Health Care Professional provided services without Your knowledge in the Participating Health Care Professional's office or practice during the same visit.

What is not a surprise bill?

If You electively seek care from an out-of-network Health Care Professional when an in-network Health Care Professional is available, any bills You receive are not considered to be surprise bills.

If You have questions about whether a bill meets this definition, call the New York State Department of Financial Services (see *Contact Information*, page 150) or visit www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills.

Additional information

You will be held harmless for any Nonparticipating Health Care Professional charges for surprise bills that exceed Your network Copayment, if You assign benefits to the Nonparticipating Health Care Professional in writing. In such cases, the Nonparticipating Health Care Professional may only bill You for Your network Copayment.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit UnitedHealthcare's website at www.myuhc.com for a copy of the form. You must mail a copy of the assignment of benefits form to Your Health Care Professional and to UnitedHealthcare at the address listed in the *Contact Information* section, page 146.

Independent dispute resolution process

Either the Medical Surgical Program or a Nonparticipating Health Care Professional may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the State. If the Nonparticipating Health Care Professional does not agree with the Medical/Surgical Program Administrator's surprise bill allowance, the Health Care Professional may submit a dispute by completing the IDRE application form and sending it the New York State Department of Financial Services. You will be held responsible for only the applicable Copayment. No action is required on Your part.

The IDRE will determine whether the Medical/Surgical Program's payment or the Health Care Professional's charge is reasonable within 30 days of receiving the dispute. In either case, You will only be responsible for any applicable network Copayment.

Confined on effective date of coverage

Delete this section.

Add the following new section after **Confined on date of change of options***:*

Confined on date of coverage cancellation

If Your coverage is canceled under this Plan and, on that date, You are confined in a Hospital or similar Facility for care or treatment or You are confined at home under the care of a Physician for a sickness, injury or pregnancy, Your Empire Plan benefits will continue until You are released from the Hospital or the home confinement under Physician care ends.

Recovery of overpayments and subrogation

Right to offset

Delete this section.

Add the following new section after **Recovery of overpayments***:*

Refund of overpayments

If the Plan pays for benefits for expenses incurred on Your account, You, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by You, but all or some of the expenses were not paid by You or did not legally have to be paid by You.
- All or some of the payment the Plan made exceeded the benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, You agree to help the Plan get the refund when requested.

If the refund is due from You and You do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for You that are payable under the Plan. If the refund is due from a person or organization other than You, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits that are payable in connection with services provided to You under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which the Medical/Surgical Program Administrator makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Utilization Review Guidelines

Throughout this section, replace "we" *and* "us" *with* "the Program Administrator."

Before **Concurrent reviews***, add the following:*

All determinations that services are not Medically Necessary will be made by:

- Licensed Physicians or
- Licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review.

The Medical/Surgical Program Administrator does not compensate or provide financial incentives to its employees or reviewers for determining that services are not Medically Necessary. The Program Administrator has developed guidelines and protocols to assist employees or reviewers with this

process. Specific guidelines and protocols are available for Your review upon request. For more information, call the Medical/Surgical Program (see *Contact Information*, page 146).

Retrospective reviews

Add the following to the end of the paragraph:

If the Program Administrator has all information necessary to make a decision but fails to make a determination within the required time frames, this will be deemed an adverse determination, subject to an internal appeal. If upon internal appeal, the Program Administrator does not make a decision within the required time frames, the adverse determination will be reversed.

Notice of adverse determination

Add the following to the end of the first paragraph:

If the Program Administrator provides a notice of adverse determination but does not attempt to consult with Your Provider who recommended the service, Your Provider may request a reconsideration of the adverse determination.

Add the following new section before **Appeals***:*

Grievance Procedures

Grievances

The Medical/Surgical Program's Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by the Medical/Surgical Program. For example, the procedure applies to contractual benefit denials or issues or concerns You have regarding the Medical/Surgical Program's administrative policies or access to Providers.

Filing a Grievance

You may contact the Medical/Surgical Program by writing to the Medical/Surgical Program Administrator (see *Contact Information*, page 146) to file a Grievance. An *Empire Member Services Request Form* is available at www.myuhc.com to assist You with writing a Grievance. You may submit an oral Grievance in connection with a denial of a covered benefit determination by calling the Medical/Surgical Program (see *Contact Information*, page 146). You or Your designee has up to 180 calendar days to file the Grievance from when You receive the decision You are asking to have reviewed.

Once the Medical/Surgical Program receives Your Grievance, the Medical/Surgical Program will mail an acknowledgment letter within 15 business days.

The Medical/Surgical Program keeps all requests and discussions confidential, and the Medical/Surgical Program will take no discriminatory action because of Your issue. The Medical/Surgical Program has a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance determination

Qualified personnel will review Your Grievance, or, if it is a clinical matter, a licensed, certified or registered Health Care Professional will review. **For an issue relating to a Medical Necessity or experimental or investigational determination, see the *Utilization Review/Clinical Appeals* section, page 94.**

The Medical/Surgical Program Administrator will review Your Grievance and will notify You of its decision within the following time frames:

Expedited/Urgent Grievances: By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Preservice Grievances: A preservice Grievance is a request regarding a service or treatment that has not yet been provided. You will be notified in writing within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances: A post-service Grievance is a claim for a service or treatment that has already been provided. You will be notified in writing within 30 calendar days of receipt of Your Grievance.

All Other Grievances: Other Grievances include all Grievances that are not related to a claim or request for a service or treatment. You will be notified in writing within 45 calendar days of receipt of all necessary information.

Second-level Grievance/administrative Appeal

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file a second-level Grievance/administrative Appeal by writing to or calling the Medical/Surgical Program Administrator (see *Contact Information*, page 146). Urgent Appeals may also be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file a second-level Grievance/administrative Appeal.

Once the Medical/Surgical Program receives Your administrative Appeal, the Program will mail an acknowledgment letter within 15 business days.

One or more qualified personnel at a higher level than the personnel who rendered the previous Grievance determination will review, or if it is a clinical matter, a clinical peer reviewer will review. The Medical/Surgical Program Administrator will decide the administrative Appeal and notify You in writing within the following time frames:

Expedited/Urgent Grievances: The earlier of two business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Preservice Grievances: A preservice Grievance is a request regarding a service or treatment that has not yet been provided. You will be notified within 15 calendar days of receipt of Your Appeal.

Post-Service Grievances: A post-service Grievance is a claim for a service or treatment that has already been provided. You will be notified within 30 calendar days of receipt of Your Appeal.

All Other Grievances: Other Grievances include all Grievances that are not in relation to a claim or request for a service or treatment. You will be notified within 30 business days of receipt of all necessary information.

Assistance

If You remain dissatisfied with the Medical/Surgical Program's Administrator's second-level administrative Appeal determination, or at any other time You are dissatisfied, You may contact the New York State Department of Financial Services (see *Contact Information*, page 150).

If You need assistance filing a Grievance or administrative Appeal, You may also contact the State Independent Consumer Assistance Program (see *Contact Information*, page 150).

Appeals

Appeal process

Rename this section **Utilization Review/Clinical Appeal process**.

External Appeals

Your right to an External Appeal

Replace this section with the following:

Under certain circumstances, You have a right to an External Appeal of a denial of coverage. Specifically, if the Medical/Surgical Program Administrator has denied coverage on the basis that:

- The service is not Medically Necessary,
- The service is an experimental or investigational treatment,
- The service is a rare disease treatment or

- The Medical/Surgical Program Administrator has denied a preservice out-of-network referral request because there is a geographically accessible in-network Provider with the appropriate training and experience to meet Your health needs.

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 experimental or investigational:

Replace the first bullet with the following:

- The service, procedure or treatment must otherwise be a Covered Service under the policy.

Add the following new section before **The external Appeal process***:*

Your right to Appeal a denied preservice request for an out-of-network Provider referral exception

If You have been denied an out-of-network referral on the basis that the Medical/Surgical Program Administrator has geographically accessible network Provider(s) with the same or higher level of training and experience to treat Your condition, You or Your representative may file an Appeal for review by an External Appeal Agent if You satisfy the following three criteria:

- The service, procedure or treatment must otherwise be a Covered Service under the policy.
- You must have received a final adverse determination through the internal Appeal process described in this *Certificate* and, if any new or additional information regarding the service or procedure was presented for consideration, the Medical/Surgical Program Administrator must have upheld the denial or You and the Medical/Surgical Program Administrator must agree in writing to waive any internal Appeal.
- Medicare is not Your primary coverage.

The external Appeal process

Replace the first sentence with the following:

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, is an experimental or investigational treatment, is a rare disease treatment or for preservice out-of-network referral denials, You have four months from receipt of such notice to file a written request for an External Appeal.

Empire Plan Mental Health and Substance Abuse Program

The following amendments apply to Plan documents for the Empire Plan Mental Health and Substance Abuse Program.

*Change all instances of "*ValueOptions*" to "*Beacon Health Options*."*

*Change all instances of "*substance abuse*" to "*substance use*" (except when used in the name of the Empire Plan Mental Health and Substance Abuse Program).*

Coverage

Replace bullets three, four and five with the following:

- Alternatives to Inpatient Services at Approved Facilities.
- Outpatient Services.
- Inpatient Services/residential rehabilitation and aftercare following hospital discharge for Substance Use Care.

Replace the remaining paragraphs after **If You have questions about the Program, You or a member of Your family or household may call the Program** *with the following:*

Calling the Program Administrator is the first step in ensuring that You will be eligible to receive the highest level of benefits under the Plan. When You call the Mental Health and Substance Abuse Program, You will have access to The Clinical Referral Line, which is available 24 hours a day, every day of the year. It is staffed by clinicians who have professional experience in the Mental Health Care and Substance Use Care field. These highly trained and experienced clinicians are available to help You determine the most appropriate Course of Treatment.

By calling the Program Administrator before You receive services, and then obtaining care from a Provider referred to You by the Program Administrator, You will receive the highest level of benefit with Network Coverage. Usually, the Program Administrator will refer You to a Network Practitioner or Network Facility. However, You will also qualify for Network Coverage if: 1.) there is no Network Provider available, and 2.) the Program Administrator specifically approved Your Referral to a Non-Network Provider.

If You choose a Non-Network Provider when a Network Provider is available to You, prior to receiving services, it is imperative that You call the Program Administrator to ensure any applicable Certification process is complete. If You choose a Non-Network Provider when a Network Provider is available, any bill from such Non-Network services in excess of the amount paid under the Plan shall be Your sole responsibility to pay.

For additional information, see references to Network and Non-Network Coverage throughout this *Certificate*.

Meaning of Terms Used

Replace the following defined terms:

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 use treatment or accredited by the appropriate State agency for the level of care received. 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. Under Network Coverage, residential treatment centers, halfway houses and group homes will be considered Approved Facilities if they satisfy the requirements listed previously and

admission is Certified by the Program Administrator. See the definitions for Network Facility and Non-Network Facility for more information. In all cases other than an emergency, the facility must also be approved by the MHSA Program Administrator. **Note:** Services received at an Approved Facility, except emergency services, are subject to a Medical Necessity determination.

E. **Certification, Certify** or **Certified** means a determination by the Program Administrator that Mental Health Care, Substance Use Care or proposed care is a Medically Necessary, Covered Service, that is provided by an Approved Facility, in accordance with the terms of this *Certificate*.

H. **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 Empire Plan's Basic Medical, Hospital and MHSA Programs. Copayments for Network Services also count toward the Combined Annual Coinsurance Maximum. After the Combined Annual Coinsurance Maximum is reached, benefits are paid at 100 percent of Usual and Customary charges for Non-Network Covered Services.

T. **Mental Health Care** refers to Medically Necessary services rendered by an Approved Facility or an eligible Provider that are:

- Intended to prevent, diagnose, correct, alleviate or preclude deterioration of a diagnosable condition (most current version of *International Classification of Diseases [ICD]* or *Diagnostic and Statistical Manual [DSM]*) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific and consistent with symptoms and diagnosis.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health care professionals or publications.
- Reflective of a level of service that is safe.
- Not primarily intended for the convenience of the recipient, caretaker or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

V. **Network Coverage** means the level of benefits provided by the Program when You receive Medically Necessary Covered Services from a Network Provider or if the Program Administrator specifically approved Your Referral to a Provider.

W. **Network Facility** means an Approved Facility that has entered into a Network Provider agreement as an independent contractor with the Program Administrator. The records of the Program Administrator shall be conclusive as to whether a facility has a Network Provider agreement in effect on the date that You obtain services. If no Network Facility is available, the Program Administrator may, on a case-by-case basis, approve Your Referral to a Non-Network Provider.

A Non-Network Facility can be considered a Network Facility on a case-by-case basis if approved by the Program Administrator in writing.

X. **Network Practitioner** means a Practitioner who has entered into an agreement with the Program Administrator as an independent contractor to provide Covered Services to You. The records of the Program Administrator shall be conclusive as to whether a Practitioner had a Network Provider agreement in effect on the date that You obtained services. If no Network Practitioner is available, the Program Administrator may, on a case-by-case basis, approve Your Referral to a Non-Network Practitioner.

AB. **Non-Network Practitioner** means a Practitioner who has not entered into an agreement with the Program Administrator as an independent contractor to provide Covered Services to You. If no Network Practitioner is available, the Program Administrator may, on a case-by-case basis, approve Your Referral to a Non-Network Practitioner.

AE. **Partial Hospitalization Program** means a freestanding or hospital-based program at an Approved Facility that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for fewer 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.

AH. **Practitioner** means:

- A psychiatrist.
- A psychologist.
- A licensed clinical social worker in New York State who qualifies for 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.
- 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).
- 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 and who 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.
- Applied Behavior Analysis (ABA) Provider (a licensed Provider 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.
- 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.

AM. **Provider** means a Practitioner or Approved Facility that supplies You with Covered Services under the MHSA Program. The fact that a Practitioner or Approved Facility provides You with Mental Health Care or Substance Use Care services does not have any bearing on whether that Practitioner or Approved Facility is a Network Provider or covered under the Program. It is Your responsibility to confirm that a Provider is in the network.

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 received any service or supply.

AN. **Referral** means the process by which the Program Administrator's 24-hour, toll-free Clinical Referral Line refers You to a Network Provider to obtain covered Mental Health Care and Substance Use Care. Or, in the rare case when no Network Provider is available, the process by which the Program Administrator's 24-hour, toll-free Clinical Referral Line approves and refers You to a Non-Network Provider.

AO. **Structured Outpatient Rehabilitation Program** means a program that provides Substance Use 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.

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.

AP. **Substance Use Care** refers to the Medically Necessary services rendered by an Approved Facility or an eligible Provider that are:

- Intended to prevent, diagnose, correct, alleviate or preclude deterioration of a diagnosable condition (most current version of *International Classification of Diseases [ICD]* or *Diagnostic and Statistical Manual [DSM]*) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific and consistent with symptoms and diagnosis.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by Substance Use Care professionals or publications.
- Reflective of a level of service that is safe.
- Not primarily intended for the convenience of the recipient, caretaker or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Add the following defined terms and re-letter the list:

C. **Autism Spectrum Disorder** is meant to include the entire range of pervasive development disorders seen in young children. It includes both the *Diagnostic and Statistical Manual IV (DSM-IV)* diagnoses of "autistic disorder" and "pervasive developmental disorder–not otherwise specified" (PPD-NOS).

AF. **Physician** means a person licensed or otherwise authorized by law to practice medicine or use the title "physician."

AG. **Plan** means The Empire Plan.

AI. **Precertification/Precertify** means the utilization review conducted prior to an admission, stay or other service or course of treatment (including outpatient procedures and services), also referred to as "Precertification review," "prior authorization," "pre-services" or "initial review."

AL. **Program Administrator Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who renders Medical Necessity decisions.

*Re-label the definition for "*Reasonable and Customary*" as "*Usual and Customary.*"*

How to Receive Services for Mental Health and Substance Use Care

Network Coverage

Rename this section **If You choose Network Coverage**.

Replace the second paragraph after the bulleted list with the following:

You are guaranteed access to Network Coverage. If You cannot locate a Network Provider in Your area, then contact the Clinical Referral Line. On a case-by-case basis, where no Network Provider is available and the Program Administrator specifically approved Your Referral to a Non-Network Provider, that Non-Network Coverage may be considered Network Coverage.

Call The Empire Plan and choose the Mental Health and Substance Abuse Program.

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.

Non-Network coverage

Rename this section **If You choose Non-Network Coverage**.

Replace the first and second paragraphs with the following:

Before You choose a Non-Network Provider, consider the high cost of treatment. Non-Network Providers can bill You for amounts significantly over the amount Network Providers can charge. **If You choose or use a Non-Network Provider, prior to receiving services, it is Your responsibility to ensure that the Non-Network Provider is an Approved Facility and it obtains required Precertification.**

For an admission that is not considered to be Emergency Care to a Non-Network Facility (including Intensive Outpatient Programs, Partial Hospital Programs, halfway houses and group homes), You must call the Program Administrator before admission to have the Medical Necessity of the admission Precertified in writing. Additionally, any Non-Network Facility must meet the requirements of an Approved Facility.

Add the following before the final paragraph of this section:

If services are received from a Non-Network Provider prior to the completion of the Precertification process by the Program Administrator and the Program Administrator ultimately denies approval of the services, You will be solely responsible for any portion of the bill not covered under the Plan.

Emergency services

Rename this section **If You need Emergency Care**.

Replace this section with the following:

In an emergency situation, You should go or be taken to the nearest hospital emergency department for treatment. If You are admitted to a facility for Emergency Care, You should call the MHSA Program for Certification within 48 hours or as soon as reasonably possible after obtaining Emergency Care.

You must pay the first $100 in charges (Copayment) for Emergency Care in a hospital emergency department. You will not have to pay this Copayment if You are treated in the emergency department 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 an emergency, the Program will provide Network Coverage until You can be transferred to a Network Facility. If You choose to be transferred to a Non-Network Facility when a Network Facility is available, You will be solely responsible for any portion of the bill not covered under this Plan.

What is Covered Under the MHSA Program

Inpatient care

Rename this section **Inpatient Services**.

Add the following to the end of item B. **Residential Treatment Facilities, Halfway Houses and Group Homes***:*

Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law, and, in other states, to Facilities that are licensed or Certified to provide the same level of treatment.

Outpatient care

Rename this section **Outpatient Services**.

Replace the following:

D. **Family Sessions.** For each patient's Substance Use Care treatment program, benefits are allowed for covered family sessions. When the patient is participating in a Structured Outpatient substance use Rehabilitation Program, up to 20 family sessions (per Calendar Year) for family members of an alcoholic, alcohol abuser or substance user covered under the same Empire Plan enrollment are covered by the Program. If the patient 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 Program Administrator Certification.

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. After the third visit, the $25 Copayment per visit applies. The Program Administrator may request documentation in order to determine if any or all visits are considered crisis intervention. **Paid-in-full benefits for these services are available under Network Coverage only.**

K. **Home-Based Counseling.** You are covered for Medically Necessary home-based counseling provided by Practitioners and following all outpatient procedures as practiced in outpatient office visits.

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. Registered 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 New York State Education Law Article 139 Section 6902.

M. **Telehealth (Delivery of Services).** If Your Provider offers Covered Services using telehealth, You will not be denied Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the *Certificate* that are at least as favorable as those requirements for the same service when not delivered using telehealth.

Add the following final sentence to item N. **Applied Behavior Analysis (ABA)***:*

There is no annual maximum for ABA services, Network and Non-Network combined.

Effective January 1, 2019, *Delete the last two sentences of item* F. **Psychological Testing and Evaluations***:*

The Network Provider must obtain the Program Administrator Certification of this care **before** testing begins. If testing is being provided by a Non-Network Provider, You **must** have Your Practitioner call the Program Administrator and obtain Certification of the care **before** testing begins.

The Program Administrator reviews Outpatient and Inpatient treatment

Rename this section **The Program Administrator reviews Outpatient* and Inpatient Services**.

Add the following note after the bulleted list:

* Not all Outpatient Services require Precertification. Please check Your Schedule of Benefits for applicable Certification requirements for Outpatient Services.

Certification denial and appeal process: Deadlines apply

Replace the final sentence of the first paragraph with the following:

You will have 180 days from the date of Your receipt of the written denial notice to request a first-level appeal.

Replace the final paragraph in this section with the following:

If an appeal involves an administrative matter, it will be reviewed by a different employee of the Program Administrator than the employee who made the original decision. Administrative appeals are reviewed by the MHSA Program Administrator.

Schedule of Benefits for Covered Services

Replace the first sentence of this section with the following:

The Program Administrator must Certify all Covered Services as Medically Necessary, regardless of whether You are using Network or Non-Network Coverage.

Add the following after the first paragraph of this section:

The following services require Precertification from the Program Administrator:

- Intensive Outpatient Program for mental health
- Structured Outpatient Program for substance use disorder
- 23-hour bed mental health/substance use disorder
- 72-hour bed mental health/substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT) – inpatient and outpatient
- Applied Behavioral Analysis (ABA)
- Group home
- Halfway house
- Residential treatment center mental health
- Residential treatment center substance use disorder*
- Partial hospitalization mental health
- Partial hospitalization substance use disorder

* Precertification is not required for OASAS-Certified Network Facilities located within New York State.

Network Coverage for Mental Health Care and Substance Use Care

Replace items A. through D. with the following:

A. You pay the first $25 charged for each visit to a Structured Outpatient Rehabilitation Program for Substance Use Care.

B. You pay the first $25 charged for any other outpatient visit, including home-based and telephone counseling in place of an office visit. However, no Copayment is required for:

- Crisis intervention, up to three visits per crisis (after the third visit, the $25 Copayment per visit applies).
- Electroconvulsive therapy (the inpatient facility and professional charges), if Certified by the Program Administrator.
- Psychiatric second opinion, if requested and Certified by the Program Administrator.
- Ambulance service.
- Mental Health Care psychiatric evaluations, if requested and Certified by the Program Administrator.
- Prescription drugs, if billed by an Approved Facility.
- Home-based counseling, when provided in place of Inpatient Services.

C. You pay the first $100 charged for Emergency Care in a hospital emergency department. You will not have to pay this Copayment if You are treated in the emergency department and it becomes necessary for the hospital to admit You at that time as an inpatient.

D. You pay the first $25 charged for each visit Precertified by the Program Administrator for Applied Behavior Analysis (ABA) therapy for Autism Spectrum Disorder. One Copayment per visit will apply for all covered ABA services rendered during that visit.

Non-Network Coverage for Mental Health Care and Substance Use Care

Replace the first two sentences with the following:

Prior to using any of the Non-Network Services, You are responsible for obtaining Mental Health and Substance Abuse Program Precertification for care obtained from a Non-Network Provider.

When You use a Non-Network Provider or a Provider not referred to You by the Program Administrator, the Plan pays the following covered percentages:

Replace the first two paragraphs about the **Combined Annual Deductible** *with the following:*

The Combined Annual Deductible is $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

Replace the two paragraphs about the **Combined Annual Coinsurance Maximum** *with the following:*

The Combined Annual Coinsurance Maximum is $3,750 for the enrollee and $3,750 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Coinsurance Maximum of $3,750.

Each $3,750 coinsurance maximum will be reduced to $1,875 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

Maximums

Delete the following sentence: Coverage for applied behavior analysis is limited to 680 hours for the 2014 plan year.

Delete the following phrase from the final sentence in this section: Beginning in 2015.

Exclusions and Limitations

Add the following and re-letter the remaining items:

O. Services or supplies received by an individual confined in a county, state or federal correctional facility.

Coordination of Benefits (COB)

Replace item C. with the following:

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 Usual and Customary Rate, whichever is less, for the service You receive.

   If The Empire Plan is secondary to Medicare, the amount payable will be determined as denoted in the *Impact of Medicare on This Plan* section, page 116.

Delete the final bullet under item E.2 and replace the first bullet under item E.2 with the following:

- The benefits of the plan of the parent whose birthday (the word “birthday” refers only to month and day in a Calendar Year, not the year in which the person was born) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year.

Impact of Medicare on This Plan

Coverage

Replace item A. with the following:

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 Care and Substance Use Care expenses will be reduced by the amount available under Medicare and the Program Administrator 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 estimated based on a percentage of approved charges 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.

Add the following and re-letter the remaining items:

D. **Amyotrophic Lateral Sclerosis (ALS)** – For those eligible for Medicare due to ALS (also called Lou Gehrig's disease), Medicare Parts A and B automatically take effect the month in which your Social Security disability insurance benefits begin.

Claims

Claim payment for Covered Services

Replace the following:

B. **Non-Network Coverage** – When You receive Non-Network Coverage that has been Precertified, You are responsible for payment of charges at the time they are billed to You. You must file a claim with the Program Administrator for services rendered under Non-Network Coverage in order to receive reimbursement. The Program Administrator pays You the Non-Network covered amount for the Covered Service You obtained if it is found to be Medically Necessary. 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 the Program. However, You may assign benefits to Your Non-Network Provider and the Program will pay the Covered Expenses for Non-Network Coverage directly to Your Non-Network Provider in lieu of paying You.

Delete item C.

How, when and where to submit claims

Replace the **How** *and* **When** *sections with the following:*

How

- If You use Network Coverage, Your Provider will submit a claim to the Program Administrator.
- If You use Non-Network Coverage, You must submit a claim. You may obtain a claim form by calling The Empire Plan and choosing the Mental Health and Substance Abuse Program. You may also download a claim form from NYSHIP Online or from the Empire Plan MHSA Program's enrollee website (see *Contact Information*, page 148). If You use Non-Network Coverage, You must meet the Combined Annual Deductible before the claims are paid.

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.

Claims must be submitted to either the Program Administrator 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 the Program Administrator within 120 days after Medicare processes the claim.

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).

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

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

Fraud

Add the following as the new final sentence of this section:

The Empire Plan will refer any allegations of fraud to the New York State Attorney General's Office for prosecution.

Utilization Review Guidelines

*Throughout this section, replace "*we*" and "*us*" with "*the Program Administrator.*"*

Retrospective reviews

Add the following to the end of the paragraph:

If the Program Administrator has all information necessary to make a decision but fails to make a determination within the required time frames, this will be deemed an adverse determination, subject to an internal appeal. If upon internal appeal, the Program Administrator does not make a decision within the required time frames, the adverse determination will be reversed.

Notice of adverse determination

Add the following to the end of the paragraph:

If the Program Administrator provides a notice of adverse determination but does not attempt to consult with Your Provider who recommended the service, Your Provider may request a reconsideration of the adverse determination.

Appeals

Add the following new section after **Appeals: 180-day deadline***:*

Appeals involving urgent situations

If an Appeal involves a situation that could seriously jeopardize Your life or health or Your ability to regain maximum function, based on a prudent layperson's judgment or the opinion of a Provider with knowledge of Your medical condition, and would subject You to severe pain that cannot be adequately managed without the care of the requested treatment, then 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).

Expedited appeal decisions regarding substance use disorder treatment, including substance use disorder services that may be subject to a court order, must occur within 24 hours if the request is received at least 24 hours prior to an inpatient discharge.

Empire Plan Prescription Drug Program

The following amendments apply to Plan documents for the Empire Plan Prescription Drug Program.

Throughout your Empire Plan Prescription Drug Program Certificate of Insurance*, update the Program Administrator's name from "*CVS/caremark*" to "*CVS Caremark*."*

In the first paragraph of this Certificate*, replace the second sentence with the following:*

For additional information about Empire Plan Medicare Rx benefits, see the *Evidence of Coverage*. (You should have received this document by mail when You became eligible for primary Medicare coverage.)

Meaning of Terms Used

*Rename the term "*First Fill*" as "*Grace Fill*."*

*Rename the term "*Medical Exception Process*" as "*Medical Exception Program*."*

*Remove the term and definition for "*No-Fault Motor Vehicle Plan*."*

Your Benefits and Responsibilities

Copayments

Replace the second through fourth paragraphs with the following:

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

- **$5** for most **Generic Drugs** or Level 1 Drugs
- **$30** for **Preferred Drugs**, Compound Drugs or Level 2 Drugs
- **$60** for **Non-Preferred Drugs**, certain **Generic Drugs** or Level 3 Drugs

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

- **$10** for most **Generic Drugs** or Level 1 Drugs
- **$60** for **Preferred Drugs**, Compound Drugs or Level 2 Drugs
- **$120** for **Non-Preferred Drugs**, certain **Generic Drugs** or Level 3 Drugs

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

- **$5** for most **Generic Drugs** or Level 1 Drugs
- **$55** for **Preferred Drugs**, Compound Drugs or Level 2 Drugs
- **$110** for **Non-Preferred Drugs**, certain **Generic Drugs** or Level 3 Drugs

Replace the second sentence in the **Note** *following the copayment amounts with the following:*

Per New York state law, the Plan covers at least one product under each of the FDA's contraceptive categories at a $0 copayment.

Supply and coverage limits

Add the following to the end of this section:

Effective August 27, 2017, You may have an initial three-month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time.

Mandatory generic substitution

Add the following before the final sentence of the sixth paragraph of this section:

You will not have to pay the Ancillary Charge.

Empire Plan Flexible Formulary

Rename this section **Empire Plan Advanced Flexible Formulary** *and relabel all references to the formulary in this Certificate, as necessary.*

Replace the last two sub-bullets in this section:

- Contain one or more active ingredients available in or are therapeutically equivalent to another covered Prescription drug in the Therapeutic Category or in an over-the-counter drug or
- Contain one or more active ingredients that is a modified version of or are therapeutically equivalent to another covered Prescription drug or in an over-the-counter drug.

New to You Prescriptions Program

Delete this section. ***Note: Effective January 1, 2019****, the New to You Prescriptions Program was discontinued.*

What is covered

Replace the following re-lettered items:

Effective January 1, 2014, C. Compound Drug(s)/Medication(s). Compound Drugs that have a claim cost to the Program that exceeds $200 will require prior authorization under this Program.

E. Grace Fill of a Specialty Drug/Medication filled at a network, non-network or Mail Service Pharmacy and subsequent fills processed by the Designated Specialty Pharmacy. Specialty Drugs/Medications identified as being for short-term therapy, for which a delay in starting therapy would not affect clinical outcome (e.g., drugs needed for the treatment of Hepatitis C), do not have a Grace Fill.

F. Oral, injectable or surgically implanted contraceptives, diaphragms and contraceptive devices that bear the legend "Rx Only," or are recommended for preventive services without cost sharing under the Patient Protection and Affordable Care Act (PPACA), including certain over-the-counter (OTC) products with a Prescription. Women's preventive services guidelines can be found at www.hrsa.gov.

H. Vitamins and supplements that are FDA-approved Prescription drugs and bear the legend "Rx Only" or are recommended for preventive services without cost sharing under the Patient Protection and Affordable Care Act (PPACA), including certain over-the-counter (OTC) products with a Prescription. PPACA preventive services recommendations can be found at www.uspreventiveservicestaskforce.org.

N. Certain preventive vaccinations in accordance with the Patient Protection and Affordable Care Act (PPACA) mandates, administered at a Vaccination Network Pharmacy, will be covered at no cost. The covered preventive vaccines are: influenza – flu, pneumococcal – pneumonia, meningococcal – meningitis and herpes zoster* – shingles.

* **Effective April 1, 2018**, Shingrix® is paid in full for enrollees and dependents age 50 and older. Zostavax® is paid in full for enrollees and dependents age 60 or older and is subject to a Level 1, 30-day supply Copayment for enrollees and dependents age 55 through 59.

Add the following items:

G. Contraceptive jellies, ointments and foams or devices with a written order from the Physician are available without cost sharing under the Patient Protection and Affordable Care Act (PPACA).

O. Bowel preparation products for colorectal cancer screenings that are FDA-approved Prescription drugs and bear the legend "Rx Only" or are recommended for preventive services without cost sharing under the Patient Protection and Affordable Care Act (PPACA). PPACA preventive services recommendations can be found at www.uspreventiveservicestaskforce.org.

Exclusions and Limitations

Replace the following re-lettered items:

C. Drugs provided by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay.

R. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease.

How to Use Your Empire Plan Prescription Drug Program

Coverage for preventive vaccines administered in a Vaccination Network Pharmacy

Replace the list of **Notes** *with the following:*

Notes:

- Regulations regarding age limits may differ by state.
- New York State restricts Pharmacists from administering vaccines to anyone younger than 18, with the exception of the influenza vaccine. The influenza vaccine may be administered by Pharmacists for persons two years of age and older.
- **Effective April 1, 2018**, The no-copayment benefit for Shingrix® applies to enrollees and dependents age 50 or older.
- The no-copayment benefit for Zostavax® applies to enrollees and dependents age 60 or older (per PPACA recommendations). Zostavax® is subject to a Level 1, 30-day supply Copayment for enrollees and dependents age 55 through 59.
- Medicare-primary enrollees and dependents already have coverage for these vaccines in a Pharmacy setting under Medicare Parts B and D.

Coordination of Benefits (COB)

Delete the final bullet under item E.2 and replace the first bullet under item E.2 with the following:

- The benefits of the plan of the parent whose birthday (the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year.

Medicare Prescription Drug Coverage

Replace the first paragraph with the following:

Empire Plan Medicare Rx is the Employer Group Waiver Program (EGWP) for Medicare-primary Empire Plan enrollees and dependents that is a Medicare Part D Prescription Drug Plan (PDP) with supplemental wrap coverage. To the extent possible, this Plan mirrors the benefits and drug coverage available to The Empire Plan's non-Medicare-primary enrollees and dependents.

Replace the **Note** *in this section with the following:*

Note: Please refer to the *Evidence of Coverage* (You should have received this document by mail when You became eligible for primary Medicare coverage) regarding secondary coverage benefits.

Empire Plan Prescription Drug Program Drug Utilization Review (DUR)

Refill too soon

Replace this section with the following:

A key component of the DUR safety process implemented for this Program is the application of the "refill too soon" (RTS) edit for all claims submitted under the Program. The RTS Program ensures that the Empire Plan Prescription Drug Program provides safety and utilization review across all supply

chains, Network Pharmacy claims, Mail Service Pharmacy or the Designated Specialty Pharmacy claims and Non-Network Pharmacy claims processed for You.

Upon processing of an incoming claim, Your Prescription drug claim history is reviewed by the systematic RTS criteria. The RTS edit will cause the claim to reject if You should have consumed (based on days' supply) less than 75 percent of Your medication on a cumulative basis. When a claim is rejected, the Pharmacist is sent a message that indicates Your next refill date. Certain drugs that have quantity-level limits, such as erectile dysfunction drugs, have more restrictive RTS limits to comply with the quantity allowed per days' supply. See *Supply and coverage limits*, page 129, for additional information.