

**JANUARY 1, 2014
EMPIRE
PLAN
CERTIFICATE**

Management/Confidential; Legislature

New York State Health Insurance Program

Empire Plan Certificate for Active Management/Confidential (M/C)
Employees of the State of New York or the Legislature and for their
enrolled dependents; and for COBRA and Young Adult Option enrollees

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



**The Empire
Plan**

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The Empire Plan Certificate of Insurance

Introduction

The Empire Plan is the result of collective bargaining between the State and unions representing its employees. It has been designed to provide you with a complete health insurance benefits package at the lowest possible cost. A number of features have been included in The Empire Plan to manage both your and your employer's costs and to ensure that you receive the most appropriate care.

This *Certificate of Insurance* describes the coverage provided by The Empire Plan. The Plan is administered by the Department of Civil Service and includes the following basic elements of coverage:

- Hospital and related expense coverage administered by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans (copayments apply for certain outpatient hospital services).
- Medical/surgical benefits administered by UnitedHealthcare Insurance Company of New York (UnitedHealthcare) for a modest copayment for certain services when you choose participating providers.
- Basic Medical coverage through UnitedHealthcare when you receive medical/surgical coverage from nonparticipating providers.
- Benefits Management Program through Empire BlueCross BlueShield for prior authorization of hospital and skilled nursing facility admissions and through UnitedHealthcare for Prospective Procedure Review of MRI, CT, PET scans and nuclear medicine tests.
- Home Care Advocacy Program through UnitedHealthcare for home care services, durable medical equipment and certain supplies.
- Managed Physical Medicine Program through UnitedHealthcare/Managed Physical Network, Inc., for chiropractic treatment and physical therapy.
- Center of Excellence for Transplants Program through Empire BlueCross BlueShield.
- Center of Excellence for Infertility Program through UnitedHealthcare.
- Center of Excellence for Cancer Program through UnitedHealthcare.
- Mental Health and Substance Abuse Program through ValueOptions.
- Prescription drug coverage through CVS/caremark.

You should familiarize yourself with The Empire Plan by reading this *Certificate* so that you will effectively be able to use the benefits the Plan provides.

Pay particular attention to the information about the Empire Plan's Benefits Management Program, the Home Care Advocacy Program, the Managed Physical Medicine Program, Transplants Program, Infertility Benefits, the Mental Health and Substance Abuse Program and prior authorization requirements for certain drugs. Designed to control costs and provide you with the most appropriate care, these features have requirements that must be met to receive the highest level of benefits.

Preventive Care Services

The federal Patient Protection and Affordable Care Act (PPACA) provides the following services received from an Empire Plan participating provider or network hospital paid at 100 percent (not subject to copayment):

- Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Recommended immunizations from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as are provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A list of covered preventive services is available at www.healthcare.gov. Use the search bar at the top of the homepage to search for “preventive services.” You may also receive a printed copy of the list by calling The Empire Plan and choosing the Medical Program.

Copayments, deductibles and coinsurance may apply to services provided during the same visit as the preventive services. For example, if a preventive service is provided during an office visit but the preventive service is not the primary purpose of the visit, any copayment, deductible or coinsurance that would otherwise apply to the office visit will still apply.

Section I: The Empire Plan Benefits Management Program

Hospital, Skilled Nursing Facility and Medical Benefits Management Program

Inpatient components of the Empire Plan Benefits Management Program are administered by the Hospital Program administrator. Outpatient components are administered by the Medical/Surgical Program administrator.

You and your family must follow Benefits Management Program procedures, described as follows, to receive maximum Empire Plan benefits. Your share of the cost will be higher if you don't follow these procedures.

Applies when The Empire Plan is primary

The Empire Plan Benefits Management Program requirements apply when The Empire Plan is your primary health insurance coverage. (The Empire Plan is primary when it is responsible for paying for health benefits first, before any other group plan, Health Maintenance Organization [HMO] or Medicare is liable for payment.) If you are eligible for Medicare, but The Empire Plan is primary because you are actively employed, these requirements apply. Requirements also apply to a Medicare-primary active employee or dependent before admission to a skilled nursing facility.

These requirements apply if you live or seek treatment anywhere in the United States, including Alaska and Hawaii.

These requirements also apply when you or your enrolled dependents have primary coverage through an HMO with secondary coverage under The Empire Plan, and you choose not to use the HMO.

If you will be admitted to a medical center or hospital operated by the U.S. Department of Veterans' Affairs, and will be using your Empire Plan benefits, you must comply with the requirements of the Empire Plan Benefits Management Program.

You must call The Empire Plan and choose the Hospital Program for preadmission certification



For preadmission certification before any elective (scheduled) hospital admission that will include an overnight stay in a hospital. You must call before the hospital admission. Call as soon as your doctor suggests admission to the hospital. Call at least two weeks in advance of the admission, if possible. If you did not receive at least two weeks' notice from your doctor, contact the Benefits Management Program immediately. The nurse will make every effort to complete the review before your admission.

Before the birth of a child. Call as soon as the doctor confirms the pregnancy. You must call again if you are admitted to the hospital during the pregnancy for complications or for anything other than the delivery of the baby.

Within 48 hours or as soon as reasonably possible after an emergency or urgent admission. This includes admission if you were scheduled for outpatient surgery and remained in the hospital overnight due to a complication (see *Hospital admission*, pages 12 and 13, for definitions of "emergency," "urgent" and "maternity" admissions).

For certification before admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility.

You must call the Empire Plan Medical Program for Prospective Procedure Review



Before having an elective (nonemergency) magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test, unless you are having the test as an inpatient in a hospital (see *Prospective Procedure Review*, page 6, for details).

Who calls?

You, a member of your family or household, your doctor or a member of your doctor's staff may place the call.

Where this section refers to "you" making the call, keep in mind that other people may also call.

However, you are responsible for seeing that the Empire Plan Benefits Management Program receives the call.

Why Benefits Management?

This Program helps protect you and The Empire Plan by avoiding unnecessary service. Empire Plan enrollees need to evaluate the medical appropriateness of services they receive. Every medical procedure includes some risk. It can be unhealthy to be overtreated or undertreated. The costs associated with unnecessary services are shrinking our health benefits dollars. Money spent on unneeded services reduces the pool of money left to cover essential treatment.

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

Read items A. through F. carefully to see how the Empire Plan Benefits Management Program benefits apply to you and your family.

A. Preadmission certification for hospital admission



To receive maximum Empire Plan benefits, you **must call** The Empire Plan and choose the Hospital Program for preadmission certification.

You **must call**:

- Before any elective (scheduled) hospital admission.
- Before the birth of a child.
- Within 48 hours or as soon as reasonably possible after an emergency or urgent admission.

In addition, you **must call** before admission to a skilled nursing facility, as explained in *Preadmission certification for skilled nursing facility admission*, page 5.

If the information about your medical condition indicates that the hospital setting is medically necessary according to nationally accepted standards, the admission will be precertified. Preadmission certification assures that Empire Plan benefits will be available to you to the full extent for covered services.

If the medical necessity of the admission is not confirmed, one of the Benefits Management Program's board-certified, practicing physician advisors will discuss the hospitalization with your doctor. If necessary, a second physician advisor from the same or related specialty as your doctor will also discuss the hospitalization and various alternatives with your doctor.

If the physician advisor does not agree that the admission is medically necessary, your admission will not be certified.

Within 24 hours after the Hospital Program administrator completes the review, it will notify the hospital, you and your doctor whether the admission is certified.

You pay a higher share of the cost if you do not follow the Empire Plan Benefits Management Program procedures

If you do not follow the preadmission certification requirements, such as:

- 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,
- You did not call the Benefits Management Program within 48 hours or as soon as reasonably possible after an emergency or urgent admission or

- You followed the procedures for emergency or urgent admissions when you should have followed the preadmission certification procedures for an elective (scheduled) admission or an admission for the birth of a child, you will be required to pay:
 - A \$200 penalty if it is determined that any portion of your hospitalization was medically necessary and
 - You will be responsible for all charges for any day it is determined that your hospitalization was not medically necessary.


You may appeal any 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 was reasonably possible.

If you call the Benefits Management Program and are told hospitalization for you or your family member is not certified, you may choose to go ahead with the hospitalization. If you do, you will be required to pay all charges.

Certification does not guarantee coverage

Certification of a hospital admission means that the Empire Plan Benefits Management Program has found the inpatient setting appropriate. This certification does not guarantee coverage. The Empire Plan Program administrators will determine eligibility and benefits as part of the claims review process. For example, although the inpatient setting may be certified for your spouse's surgery, benefits are not available if you discontinued his or her coverage before the admission. As another example, if the hospital setting was approved for surgery that the Program administrators later determine to be cosmetic surgery or an experimental or investigative procedure, benefits are not available. The Empire Plan does not cover cosmetic surgery and experimental or investigative procedures or related hospital care. Call the Hospital Program or the Medical Program if you have questions about benefits for hospitalization or a certain procedure.

Preadmission certification for skilled nursing facility admission

 You must call The Empire Plan and choose the Hospital Program for preadmission certification before admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility. By calling prior to admission, you will know whether your care in a skilled nursing facility meets the criteria for Empire Plan benefits. Also, if your stay is precertified, you, your doctor and the facility will be notified no later than the day before your certification for skilled nursing facility care will end.

If The Empire Plan is your primary coverage, skilled nursing facility care is covered under The Empire Plan if:

- The care in a skilled nursing facility is medically necessary. Care is medically necessary when it must be provided by skilled personnel to assure your safety and achieve the medically desired result and
- Inpatient hospital care would have been required if care in a skilled nursing facility were not provided.

If the above conditions are not met, the skilled nursing facility care is not covered under The Empire Plan. Retirees, vestees and dependent survivors and their dependents who are eligible to receive primary benefits from Medicare have no Empire Plan skilled nursing facility benefits, even for short-term rehabilitative care. Empire Plan skilled nursing facility benefits are available to active enrollees and their dependents, regardless of Medicare eligibility.

Custodial care is not covered under The Empire Plan. Custodial care is care that is primarily for assisting with the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care. Examples of custodial care include, but are not limited to, walking, bathing, dressing, assistance in walking, getting in and out of bed, feeding or using the toilet.

Preadmission certification for transplant surgeries



You must call The Empire Plan and choose the Hospital Program for preadmission certification of admissions for the following transplant surgeries: bone marrow, peripheral stem cell, cord blood stem cell, heart, heart-lung, kidney, liver, lung and simultaneous kidney-pancreas. **This requirement applies whether or not you choose to participate in the Center of Excellence for Transplants Program.**

B. Concurrent review

Once you or your enrolled dependent is hospitalized, the Empire Plan Benefits Management Program will continue to monitor your progress through the concurrent review program. The goal of concurrent review is to encourage the appropriate use of inpatient care. If the Benefits Management Program determines that inpatient care is no longer medically necessary, you, your doctor and the facility will be notified in writing no later than the day before the day on which Empire Plan inpatient benefits cease.

Note: The Benefits Management Program only gives advance notice that inpatient benefits will cease because inpatient care is no longer medically necessary. To check when your hospital benefits will cease for other reasons, contact the Hospital Program (see *Contact Information*, page 128).

C. Discharge planning

If you or your enrolled dependent needs special services after hospitalization, the Hospital Program discharge planning unit nurses can help in consultation with hospital discharge planners. In consultation with your doctor, the discharge planning nurse will help arrange for medically necessary services and coordinate these services for you and your family. These services will be covered in accordance with Empire Plan provisions. For home health care and durable medical equipment/supplies, you must call the Home Care Advocacy Program, as explained in the *Home Care Advocacy Program (HCAP)* section, page 57.

D. Prospective Procedure Review



To receive maximum Empire Plan benefits, you must call the Empire Plan Medical Program if you or one of your enrolled dependents is scheduled for an elective (nonemergency) magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test, unless you are having the test as an inpatient in a hospital.

Call as soon as your doctor suggests one of these procedures. Call at least two weeks before the scheduled test. If you did not receive at least two weeks' notice from your doctor, call the Empire Plan Benefits Management Program immediately. If you do not receive written confirmation from The Empire Plan, call the Benefits Management Program **before** you go ahead with the procedure.

Your call will start the review process

A Benefits Management Program representative will call your doctor to discuss his or her recommendation. If the Medical/Surgical Program administrator determines that the magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test is medically necessary and appropriate, the procedure will be approved and covered in accordance with Empire Plan provisions. Written notice will be mailed to you within 24 hours.

If the Medical/Surgical Program administrator determines that the procedure is not medically necessary, you may choose to proceed with the procedure. If it is determined through retrospective review that your procedure was not medically necessary, you will be responsible for the full cost of the procedure. You will receive no Empire Plan benefits.

You do not have to call before an emergency magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test. When the Hospital or Medical/Surgical Program administrator receives the claim for the procedure, the administrator will determine whether it was performed on an emergency basis and whether it was medically necessary.

A magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test is performed on an emergency basis when it is given within 72 hours after an accident or within 24 hours after the first appearance of the symptoms of the illness if there is a sudden, unexpected onset of a medical condition and immediate care is necessary to prevent what could reasonably be expected to result in either placing your life in jeopardy or serious impairment to your bodily functions.

There are penalties for not complying with the Prospective Procedure Review requirements

If you fail to call the Empire Plan Benefits Management Program, the Hospital Program administrator and/or the Medical/Surgical Program administrator will conduct a medical necessity review. If the review does not confirm that the magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test was medically necessary, you will be responsible for the full charges. No benefits will be paid under your Empire Plan coverage.

If you fail to call the Benefits Management Program and the Hospital and/or Medical/Surgical Program administrator review confirms that the procedure was medically necessary but not an emergency, you will be responsible for paying the following:

- When the procedure is performed in the outpatient department of a hospital, you are liable for the payment of the lesser of 50 percent of the covered hospital charge or \$250. You will also be responsible for the applicable outpatient hospital copayment or coinsurance.
- When the provider(s) administering and/or interpreting the procedure is an Empire Plan participating provider under the Medical/Surgical Program, you are liable for the payment of the lesser of 50 percent of the scheduled amounts or \$250. You will also be responsible for the Medical/Surgical Program copayment.
- When the provider(s) administering and/or interpreting the procedure is not an Empire Plan participating provider, you are liable for the lesser of 50 percent of the reasonable and customary charges or \$250. In addition, you must meet your combined annual deductible and you must pay the coinsurance and any provider charges above the reasonable and customary amount. (The coinsurance is the 20 percent you pay for covered services by nonparticipating providers, up to an annual maximum.)

Voluntary specialist consultant evaluation

You may request a voluntary specialist consultant evaluation for any scheduled procedure. Call The Empire Plan and choose the Medical Program for a list of up to three physicians whose specialty is similar to your doctor's. After you determine which of these doctors you prefer to see, the Benefits Management Program will arrange for the specialist consultant evaluation. The consultation will be provided at no cost to you.

However, if the specialist from whom you obtained the specialist consultant evaluation performs the procedure, the specialist consultant evaluation will not be considered a covered expense under The Empire Plan; you will be responsible for the cost of the evaluation.

Once the evaluation is completed, it is up to you whether to have the procedure or surgery. But remember, if you decide to go ahead and will be admitted to the hospital for the procedure, you must call The Empire Plan and choose the Hospital Program for preadmission certification.

E. Medical case management

Medical case management is a voluntary program to help you identify and coordinate covered services.

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

Preadmission certification and concurrent review help the Benefits Management Program determine if medical case management would be appropriate. If the Benefits Management Program decides that this service could help you and your family, a nurse coordinator who is familiar with benefits available under The Empire Plan and local and regional health care resources will contact you. The nurse will contact you to discuss your medical situation.

Your acceptance of this service is voluntary. With your written consent, the nurse and your attending physician will identify treatment options covered under The Empire Plan so that you and your family have the information available to make the best medical decisions possible. The nurse will also identify any community resources that may be available for you or your family.

When you accept medical case management, your care will be coordinated by a nurse from the appropriate Program.

F. Future Moms Program

The Empire Plan Benefits Management Program offers special help for pregnant women. Call The Empire Plan and choose the Hospital Program as soon as you know you are pregnant. The Benefits Management Program will help identify possible problems and will work with you and your doctor to ensure you have a healthy pregnancy and safe delivery. See the following for details.

Future Moms Program

Pregnant? First steps

When your primary coverage is The Empire Plan, the Empire Plan Future Moms Program provides you with special services.

Step 1. Call your doctor

As soon as you think you are pregnant, call your doctor. The first three months of pregnancy are when you can do the most for your baby. Try to start your doctor visits during the first month of pregnancy.

Step 2. Call The Empire Plan and choose the Hospital Program

Doctors report problems in three out of every ten pregnancies. But there's good news: **Early diagnosis and care can mean a healthy baby.**

The Benefits Management Program helps identify possible problems and works with mother and doctor throughout the pregnancy. This partnership can make a world of difference.

Call The Empire Plan and choose the Hospital Program as soon as you know you are pregnant. Call early, during the first month is best. If you don't call before your maternity hospital admission, you pay a higher share of the cost.

Tell the Benefits Management Program you're calling about your pregnancy. The maternity specialist will ask you several easy questions such as, "Is this your first pregnancy?" and "Have you had problems during previous pregnancies?" These questions can help determine if you or your baby is at risk.

The questions take a few minutes at the most, and your answers are strictly confidential.

Free Pregnancy Resource: When you call, the Benefits Management Program will offer to send you a kit that includes a helpful booklet that can be used as a reference throughout your pregnancy.

Follow-Up Care: If the maternity specialist identifies any possible problems, the specialist will ask to keep in telephone contact with you every four to six weeks. Your participation is voluntary.

One of the Program's registered nurses who specializes in maternity or newborn care will call you back to talk with you about your progress and any problems you are experiencing. The nurse also will call your doctor to discuss progress and possible follow-up actions.

During these calls, you may ask questions, too. The nurse will answer general questions. If you need help determining what questions to ask your doctor, the nurse will help you think through those questions.

Note: Be sure the Benefits Management Program has been notified of your pregnancy before your maternity admission. If your baby remains in the hospital after you are discharged from your maternity admission, be sure to contact the Benefits Management Program for certification of additional days.

Step 3. Be informed

Ask a lot of questions. Ask your doctor and nurse and check with community resources for answers to your questions.

Remember to contact your Health Benefits Administrator within 30 days of the date of birth to add your newborn to your Empire Plan coverage.

More About the Benefits Management Program

Certification letter

The Benefits Management Program will mail a letter to you within 24 hours after The Empire Plan Prospective Procedure Review and/or preadmission certification review is completed. If your letter has not arrived, call the Benefits Management Program before your procedure or admission to find out the results of the review.

Call again

 **YOU MUST CALL** You **must call** the Benefits Management Program again in certain situations:

Admission Postponed: If you received certification for admission to a hospital or skilled nursing facility and there is a change in the scheduled date of your admission, you must call the Benefits Management Program again to change the date.

Readmission: If you received preadmission certification for a hospital or skilled nursing facility admission and you must be readmitted for the same problem, you must call the Benefits Management Program again.

Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) or Nuclear Medicine Test Postponed: If the Benefits Management Program approved your MRI, MRA, CT, PET or nuclear medicine test but you and your doctor decide to postpone the procedure for more than six months, you must call again for another review when the procedure is rescheduled.

Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) or Nuclear Medicine Test Repeated: If you followed Prospective Procedure Review requirements for a procedure and the procedure is scheduled to be repeated, you must call the Benefits Management Program again.

The Benefits Management Program and the Mental Health and Substance Abuse Program

The Benefits Management Program does not replace the Empire Plan Mental Health and Substance Abuse Program. Call The Empire Plan and choose the Mental Health and Substance Abuse Program before seeking care for mental health and substance abuse problems, including alcoholism.

At times, a person's condition may be so complicated that it is difficult to determine if the required care is medical or mental health/substance abuse related. If you cannot decide, call either the Mental Health and Substance Abuse Program or the Benefits Management Program to determine which Program applies.

Calling the Empire Plan Benefits Management Program Is Easy and Toll Free

You may call The Empire Plan and choose either the Hospital Program or the Medical Program, depending on the services to be precertified (see *Contact Information*, page 128). If you call outside normal business hours or on holidays, leave a message and a representative will return your call. Please leave your name, phone number (including area code) and the best time and place to reach you on the following business day. If you don't get a return call in one business day, your message may not have been clear. Please call again.

Be ready to supply the following information to the nurse:

- Enrollee identification number (from your Empire Plan Benefit Card).
- Patient's address and phone number (including area code).
- Doctor's name, address and phone number (including area code).
- Name of hospital or skilled nursing facility.
- Anticipated or scheduled date for magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) or nuclear medicine test.

Section II: The Empire Plan Hospital and Related Expenses Certificate of Insurance

Introduction

- A. **Your Hospital Program Coverage Under The Empire Plan.** Under The Empire Plan, the Hospital Program administrator will provide benefits for hospitalization and related expenses as described in this book. These benefits will be referred to in this section of the book as “this Plan.” This book is your *Certificate*, which is evidence of your insurance. You should keep this book with your other important papers so it is available for your future reference. It is also important for you to be aware of the provisions of your coverage, because failure to comply with some of them could result in a reduction in benefits.
- B. **Words the Hospital Program Uses in This Section.** The word “you,” “your” or “yours” refers to you, the employee to whom this book is issued, and to any members of your family who are also covered under this Plan.

Network Hospitals and Facilities means hospitals and facilities that participate in the BlueCross and BlueShield Association Blue Card PPO® Program through local BlueCross and/or BlueShield plans. When you use network hospitals and facilities, covered services are paid in full subject to the Benefits Management Program requirements and any applicable copayments that you pay.

Non-Network Hospitals and Facilities means hospitals and facilities that do not participate in the BlueCross and BlueShield Association Blue Card PPO® Program network. When you use non-network hospitals and facilities, you must pay a higher share of the cost of covered services. Network benefits may apply at non-network facilities under certain circumstances (see *Network and Non-Network Benefits*, pages 13 and 14).

Program Administrator means the company contracted by the State of New York to administer the Empire Plan Hospital Program. The Hospital Program administrator is Empire BlueCross BlueShield. Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans. The Program administrator is responsible for processing claims at the level of benefits determined by The Empire Plan and for performing all other administrative functions under the Empire Plan Hospital Program.

- C. **Who Is Covered.** Eligibility for coverage is determined under Regulations of the President of the New York State Civil Service Commission. Refer to your *General Information Book* for information on your eligibility for coverage. Also, refer to the *General Information Book* for an explanation of how you enroll in The Empire Plan, which dependents are covered under The Empire Plan and when your coverage becomes effective.
- D. **If You Are Eligible for Medicare.** If you are eligible for primary Medicare coverage, your benefits under this Plan will change. Be sure to read *Limitations and exclusions*, page 24, and *If You Qualify for Medicare*, page 29, which describe benefits under this Plan for persons who are eligible for Medicare.
- E. **If You Are Disabled on the Date Your Coverage Becomes Effective.** If you have a prior confinement in a hospital, skilled nursing facility or other institution for care or treatment immediately preceding the date your coverage under The Empire Plan becomes effective and the confinement continues on the day this Plan becomes effective, or you continue to be confined at home under the care of a physician or surgeon, because of a disabling sickness or injury on the date your coverage under this Plan becomes effective, the Hospital Program will not provide benefits to the extent that you have coverage under any other health care plan, including provisions for benefits after termination in the event of disability. Hospital Program benefits will be payable only to the extent that they exceed the benefits payable under the other health care plan.

- F. **Empire HealthChoice Assurance, Inc., doing business as Empire BlueCross BlueShield, is an insurance company organized under the laws of New York State, and is a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.** It is not acting as an agent of the BlueCross and BlueShield Association and is solely responsible for honoring its agreement to administer The Empire Plan hospitalization and related expenses coverage.

Benefits Management Program

You must call The Empire Plan and choose the Hospital Program.



If The Empire Plan is your primary coverage, all of the inpatient hospital benefits and skilled nursing facility benefits provided by the Hospital Program administrator are subject to the provisions of the Empire Plan Benefits Management Program. Please read about the Benefits Management Program requirements in the preceding section of this book.

Hospital admission

If you do not follow the provisions of the Benefits Management Program, the Hospital Program administrator will still review your claim and will apply the following penalties and copayments:

- If 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, a \$200 penalty will apply. No payment will be made for any day during which it was not medically necessary for you to be an inpatient.
- If you called the Benefits Management Program and did not receive certification for your admission and you are admitted to the hospital as an inpatient, you will be responsible for all charges for each day it was not medically necessary for you to be an inpatient. If only a part of your inpatient stay was certified, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.
- If you did not call the Benefits Management Program within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission, a \$200 penalty will apply. In addition, you will be responsible for all charges for each day it was not medically necessary for you to be an inpatient.

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 was 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. In addition, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

Emergency Admissions. An emergency admission is an admission for:

- A. A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the person afflicted with such condition, or, with respect to a pregnant woman, the health of the woman and the unborn child in serious jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy,
 - Serious impairment to such person's bodily functions,
 - Serious dysfunction of any bodily organ or part of such person or
 - Serious disfigurement of such person.
- B. A condition described in clause (i), (ii) or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

Urgent Admissions. Urgent admissions involve medical conditions or acute trauma such that medical attention, while not immediately essential, should be provided very early in order to prevent possible loss or impairment of life, limb or body function.

Maternity Admissions. A maternity admission is one in which a pregnant patient is admitted to give birth. Admissions for incomplete abortion, toxemia and ectopic pregnancy are not considered maternity admissions. These will be considered as either urgent or emergency admissions, and you must call the Benefits Management Program within 48 hours. **Note:** Under New York State law, the first 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or the first 96 hours following a cesarean section are presumed to be medically necessary.

If you fail to comply with the requirements of the Benefits Management Program and your hospital admission is not certified, only the penalties referred to above will apply; your claim will not be denied completely. However, in no case will benefits be paid for services that are contractually excluded, regardless of compliance with the Benefits Management Program provisions. See *Limitations and exclusions*, page 24, for a list of exclusions.

Skilled nursing facility admission

If you did not call the Benefits Management Program to precertify your care in a skilled nursing facility, including transfer from a hospital to a skilled nursing facility, a \$200 penalty will apply and the Hospital Program administrator will conduct a medical necessity review of your skilled nursing facility stay. You will be responsible for the full charges for each day that it was not medically necessary for you to be in a skilled nursing facility. If Medicare is your primary coverage, there are no benefits for a skilled nursing facility admission.

Outpatient MRI, MRA, CT, PET and nuclear medicine tests

If you did not follow the Prospective Procedure Review requirements for magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) scans or nuclear medicine tests and the procedure was performed in the outpatient department of a hospital, the Hospital Program administrator will conduct a medical necessity review.

If the review does not confirm that the procedure was medically necessary, you will be responsible for the full charges. No benefits will be paid under your Hospital Program coverage. If you fail to call the Benefits Management Program and the Hospital Program administrator's review confirms that your procedure was medically necessary, but not an emergency, you will be responsible for paying the lesser of 50 percent of the covered hospital charge or \$250. The applicable hospital outpatient copayment or coinsurance will be applied to the remaining covered charge.

Veterans' hospital admission

If you will be admitted to a medical center or hospital operated by the U.S. Department of Veterans' Affairs for non-military service related conditions, Empire Plan benefits will be available. You must comply with the requirements of the Empire Plan Benefits Management Program if The Empire Plan is your primary coverage. Please see *Limitations and exclusions*, page 24, for more information.

Network and Non-Network Benefits

The following applies to enrollees who have primary coverage through The Empire Plan.

There are two levels of benefits under the Hospital Program: network and non-network.

• **Network Benefits:** When you use a network hospital, skilled nursing facility or hospice care facility, inpatient and outpatient covered services are paid in full except for:

- A. Any applicable hospital outpatient copayments. Hospital emergency room visits are subject to a \$70 copayment, outpatient surgical expenses are subject to a \$60 copayment, diagnostic outpatient services (diagnostic radiology, including mammography; diagnostic laboratory tests and administration of Desferal for Cooley's Anemia) are subject to a \$40 copayment and physical therapy services are subject to a \$20 copayment and

- B. Any penalty amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.
- **Non-Network Benefits:** When you use a non-network hospital, skilled nursing facility or hospice care facility, you are responsible for a larger share of the cost of covered services, unless the criteria listed under “Network Benefits at a Non-Network Hospital/Facility” below apply. You are responsible for:
 - A. 10 percent of the billed charges for inpatient hospital, skilled nursing facility or hospice care facility services up to the combined annual coinsurance maximum,
 - B. 10 percent of the billed charges or a \$75 copayment for hospital outpatient services, whichever is greater, up to the combined annual coinsurance maximum and
 - C. Any penalty amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.

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

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

Each \$3,000 coinsurance maximum will be reduced to \$1,500 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, Hospital and Mental Health and Substance Abuse (MHSA) Programs are applied to the combined annual coinsurance maximum. Copayments for participating provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum.

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

- **Network Benefits at a Non-Network Hospital/Facility:** If you use non-network hospitals and facilities, you will receive network benefits for covered services:
 - A. When no network facility is available within 30 miles of your residence.
 - B. When no network facility within 30 miles of your residence can provide the covered services you require.
 - C. When the admission is deemed an emergency or urgent inpatient or outpatient service.
 - D. When care is received outside the United States.
 - E. When another plan, including Medicare, is providing primary coverage.

The payment for medically necessary covered services received in a non-network hospital is made directly to you. You pay any applicable outpatient copayment at the network level and any penalties or coinsurance amounts that apply because of your failure to follow the requirements of the Benefits Management Program. You are responsible for making the payment to the non-network hospital.

Empire Plan network hospitals, hospices and skilled nursing facilities are listed on NYSHIP Online (see *Contact Information*, page 128). Select Using Your Benefits and then Empire Plan Providers, Pharmacies and Services. You can also call The Empire Plan and choose the Hospital Program.

Inpatient Hospital Care

The Plan will pay for your care when you are an inpatient in a hospital or birthing center as described as follows. Benefits are subject to the requirements of the Empire Plan Benefits Management Program if The Empire Plan is your primary coverage.

- **In a Hospital.** The term “hospital” means only an institution that meets fully every one of the following criteria:

- A. Is primarily engaged in providing on an inpatient basis diagnostic and therapeutic services for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice.
 - B. Continuously provides 24-hour-a-day nursing service by or under the supervision of registered professional nurses.
 - C. Is not a skilled nursing facility and is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.
- **Hospital Services Covered.** The Hospital Program will usually pay, subject to network and non-network benefit levels, for all the diagnostic and therapeutic services provided by the hospital. However, the service must be given by an employee or an agent of the hospital, the hospital must bill for the service as part of the hospital's charges, and the hospital must retain the money collected for the service. Those services include, but are not limited to:
- A. Semi-private room. A semi-private room is a room that the hospital considers to be semi-private. If you occupy a private room, the Hospital Program will only pay the hospital's most common semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.
 - B. Use of operating, recovery, intensive care and cystoscopy rooms and equipment.
 - C. Laboratory and pathology examinations.
 - D. Basal metabolism tests.
 - E. Use of cardiographic equipment.
 - F. Oxygen and use of equipment for administration.
 - G. Prescribed drugs and medicines.
 - H. Intravenous preparations, vaccines, sera and biologicals.
 - I. Blood and/or blood products, upon satisfactory evidence that local conditions make it necessary to incur expenses for blood or blood products.
 - J. Use of transfusion equipment.
 - K. Dressings and plaster casts.
 - L. X-ray examinations, radiation therapy and radioactive isotopes.
 - M. Chemotherapy, except if you are enrolled in the Center of Excellence for Cancer Program and receiving care at a Cancer Resource Services network facility. Refer to *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance* for additional information.
 - N. Anesthesia supplies, equipment and administration by a hospital staff employee.
 - O. Physiotherapy and hydrotherapy.
 - P. Ambulance service when supplied by the admitting hospital.
 - Q. Maternity care for mother and newborn for at least 48 hours after any delivery other than a cesarean section and for at least 96 hours after a cesarean section. Covered hospital maternity care includes parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.

You have a paid-in-full benefit for one maternity home care visit when you choose to be discharged from a hospital or birthing center less than 48 hours after any delivery other than a cesarean section or less than 96 hours after a cesarean section. If you choose early discharge, you must request the maternity home care visit within 48 hours after any delivery other than a cesarean section or within 96 hours after a cesarean section. The maternity home care visit will be made within 24 hours of your request or your discharge, whichever is later.

- R. The full length of your inpatient stay as determined by you and your doctor following lymph node dissection, lumpectomy or mastectomy for treatment of breast cancer.
- **Birth Center.** The Hospital Program will pay for the hospital services described in “Hospital Services Covered” on the previous page for your maternity care in a birthing center licensed by the state in which it operates.

See *Number of Days of Care*, page 20, for more information.

Outpatient Hospital Care

When you receive the services described in the following sections and subject to the limitations in those sections, the Hospital Program will pay for the same services provided to you in the outpatient department of a hospital as it pays when you are an inpatient in a hospital as described under *Inpatient Hospital Care*, page 14. This coverage also applies to services provided at a hospital extension clinic (a remote location including outpatient surgical locations and urgent care centers) owned and operated by the hospital. As in the case of inpatient care, the service must be given by an employee or an agent of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service.

- **Emergency Care.** Emergency care is care received for an emergency condition. An emergency condition is:
 - A. A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:
 - Placing the health of the person afflicted with such condition, or, with respect to a pregnant woman, the health of the woman and the unborn child in serious jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy,
 - Serious impairment to such person’s bodily functions,
 - Serious dysfunction of any bodily organ or part of such person or
 - Serious disfigurement of such person.
 - B. A condition described in clause (i), (ii) or (iii) of Section 1867(e)(1)(A) of the Social Security Act.
- **Surgery.** The Hospital Program will not pay for follow-up care for after surgery, such as removal of sutures and check-up visits.
- **Diagnostic Radiology and Laboratory Tests.** Diagnostic radiology and laboratory tests will be paid only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your doctors. You must be physically present at the outpatient department. Payment will not be made for doctors’ charges for interpretations of radiology procedures or laboratory tests, except as noted in the following.
- **Preadmission and Presurgical Testing.** All of the following conditions must be met:
 - A. The tests are ordered by a physician as a preliminary step toward inpatient or outpatient surgery.
 - B. They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed.
 - C. You have a reservation for a hospital bed or the operating room before the tests are given.
 - D. You are physically present at the hospital when the tests are given.
 - E. Surgery or admission takes place within 14 days after the tests are given or is canceled as a result of the preadmission/presurgical tests.

- **Physical Therapy.** The Hospital Program will pay for physical therapy only when all of the following conditions are met:

- A. The treatments are ordered by your doctor.
- B. The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery.
- C. The treatments must start within six months from your discharge from the hospital or within six months from the date outpatient surgery was performed.
- D. No payment will be made for physical therapy given after 365 days from the date you were discharged from the hospital or the date of the surgery.

You pay a \$20 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.

- **Dialysis Treatment.** The treatments must be ordered by your doctor.
- **Chemotherapy and Radiation Therapy.** The Hospital Program administrator pays for chemotherapy and radiation therapy (except if you are enrolled in the Center of Excellence for Cancer Program and receiving care at a Cancer Resource Services network facility. If you enroll in the Center of Excellence for Cancer Program, enhanced benefits and special provisions apply [see *Center of Excellence for Cancer Program*, page 65]). The treatment must be ordered by your doctor. Intravenous chemotherapy, oral chemotherapy, subcutaneous injections and intramuscular injections are covered by the Hospital Program only if the outpatient hospital setting is medically necessary.
- **Mammography.** Coverage is available under these conditions:
 - A. Upon the recommendation of a physician, a mammogram for covered persons at any age having a prior history of breast cancer, or who have a first-degree relative with a prior history of breast cancer.
 - B. A single baseline mammogram for covered persons ages 35 through 39 years, inclusive.
 - C. An annual mammogram for covered persons age 40 and older, or more frequently upon the recommendation of a physician.
- **Administration of Desferal for Treatment of Cooley's Anemia.** This treatment must be ordered by your doctor and must be performed by a hospital qualified to provide this service as determined solely by the Hospital Program administrator.
- **Bone Mineral Density Measurements or Tests.** Bone mineral density measurements or tests include those measurements or tests covered under the federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including dual-energy X-ray absorptiometry.

The Hospital Program will pay for bone mineral density measurements or tests when delivered in the outpatient department of a hospital if you meet the criteria of New York State Insurance Law, the federal Medicare program criteria or the National Institutes of Health criteria, and, at a minimum, meet the following conditions:

 - A. You have been previously diagnosed as having osteoporosis or you have a family history of osteoporosis,
 - B. You have symptoms or conditions indicative of the presence, or the significant risk of osteoporosis,
 - C. You are on a prescribed drug regimen that poses a significant risk of osteoporosis,
 - D. You have lifestyle factors that pose a significant risk of osteoporosis or
 - E. You have age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

Copayment for emergency care

You must pay the first \$70 in charges (copayment) for emergency care in a hospital emergency room. See *Outpatient Hospital Care*, page 16, for emergency care. Hospitals may require payment of this charge at the time of service.

The emergency room copayment covers use of the facility for **emergency care** and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and pathology services. Refer to *What is covered under the Basic Medical Program (nonparticipating providers)*, page 53, in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, if you receive bills for hospital emergency room service from these providers.

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

Copayment for outpatient hospital services

Except as noted, you must pay the first \$60 (copayment) for outpatient surgical expenses and the first \$40 (copayment) for one or more of the diagnostic outpatient services, 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.
- Administration of Desferal for treatment of Cooley's Anemia.

One copayment (\$60 if surgery is included or \$40 if it is not) covers the outpatient facility and will apply for all covered hospital outpatient services.

You will not have to pay the copayments for outpatient surgical expenses or hospital outpatient expenses if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you at that time as an inpatient.

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

There is no copayment for covered birth control surgeries provided at a network facility.

There is no copayment for the following covered hospital outpatient services provided at a network facility:

- Preadmission testing and/or presurgical testing prior to inpatient admission.
- 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.

Skilled Nursing Facility Care

Benefits are subject to the requirements of the Empire Plan Benefits Management Program. The Empire Plan does not provide skilled nursing facility benefits, even for short-term rehabilitative care, for retirees, vestees and dependent survivors or their dependents who are eligible for primary benefits from Medicare.

A. **Conditions for Skilled Nursing Facility Care.** The Hospital Program will pay for your care in a skilled nursing facility described in item B. below when you meet the following conditions:

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

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

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

- Coverage will only be provided for as long as inpatient hospital care would have been required if care in a skilled nursing facility were not provided. If your care is precertified, you, your doctor and the facility will be notified no later than the day before your certification for skilled nursing facility care will cease.
- Benefits in a skilled nursing facility are not provided by the Hospital Program if you are eligible to receive primary benefits from Medicare, even if you fail to enroll in Medicare. You are not eligible to receive Hospital Program benefits if your Medicare benefits for skilled nursing facilities have been exhausted.

Refer to your *General Information Book* for information on primary coverage under Medicare.

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

- A facility that is accredited as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations or
- Certified as a participating skilled nursing facility under Medicare.

Coverage is subject to the network and non-network level of benefits.

C. **Covered Services.** The Hospital Program will pay the charges of a skilled nursing facility for:

- A semi-private room. If you occupy a private room, the Hospital Program will pay an amount equal to the facility's most common charge for a semi-private room. You must pay the excess portion of the charge.
- Physical, occupational and speech therapy.
- Medical social services.
- The drugs, biologicals, supplies, appliances and equipment furnished for use in the facility and that are ordinarily provided by the facility to inpatients.
- Other services necessary for your health that are generally provided by the facility.

See *Number of Days of Care*, page 20, for more information.

Hospice Care

A. **Hospice Organizations.** The Hospital Program will pay for hospice care provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided.

Coverage is subject to the network and non-network level of benefits.

B. **Hospice Agreements.** The hospice organization must have an operating agreement with a BlueCross Plan. The operating agreement must state the method that will be used to pay for the hospice care.

- C. **Hospice Care Covered.** Hospice care is covered during the period when the hospice has accepted you for its hospice program. The following services provided by the hospice organization are covered:
- Bed patient care either in a designated hospice unit or in a regular hospital bed.
 - Day care services provided by the hospice organization.
 - Home care and outpatient services that are provided by the hospice and for which the hospice charges you. The services may include at least the following:
 - Intermittent nursing care by an R.N., L.P.N. or home health aides.
 - Physical therapy.
 - Speech therapy.
 - Occupational therapy.
 - Respiratory therapy.
 - Social services.
 - Nutritional services.
 - Laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms.
 - Medical supplies.
 - Drugs and medications prescribed by a physician that are considered approved under the U.S. Pharmacopoeia and/or National Formulary. The Hospital Program will not pay when the drug or medication is of an experimental nature, except as otherwise required by law.
 - Medical care provided by the hospice physician.
 - Respite care.
 - Bereavement services provided to your family during your illness and until one year after death.

Number of Days of Care

The Empire Plan Hospital Program will pay up to 365 benefit days of care for each spell of illness. The days of care may be for inpatient hospital care, maternity care in a birthing center or skilled nursing facility care.

A spell of illness begins when you are admitted to:

- A hospital or birthing center or
- A skilled nursing facility.

The spell of illness ends when, for a period of at least 90 days, you have not been a patient:

- In a hospital or birthing center or
- In a skilled nursing facility.

Inpatient Hospital Care. Each day of inpatient hospital care or care in a birthing center counts as one day of care toward the 365-benefit-day limit.

Skilled Nursing Facility Care. Each day of care in a skilled nursing facility counts as one-half benefit day of care. For example, 20 days in a skilled nursing facility count as 10 benefit days of care toward the 365-benefit-day limit. To check when benefits will end for care in a skilled nursing facility, contact the Hospital Program administrator. You will not be sent notice.

Outpatient Hospital Care and Hospice Care. Outpatient hospital care is provided whenever you meet the requirements. See *Outpatient Hospital Care*, page 16, for details. The 365-benefit-day limitation does not apply to outpatient hospital care. Hospice care is provided for the length of time that the hospice has accepted you for its program. The 365-benefit-day limitation does not apply to hospice care. See *Hospice Care*, page 19, for more information.

Center of Excellence for Transplants Program

If you choose to participate in the Center of Excellence for Transplants Program, you receive enhanced benefits as detailed below. The enhanced benefits include travel reimbursement and a paid-in-full benefit for services covered under the Program and performed at a qualified Center of Excellence. Participation in the Center of Excellence for Transplants Program is voluntary, but the enhanced benefits under the Program are available only when you are enrolled in the Program, when The Empire Plan is your primary coverage and your transplant services are preauthorized by the Hospital Program administrator.

If an enrollee has secondary coverage under The Empire Plan, and the enrollee's primary coverage/Health Maintenance Organization (HMO) denies coverage at a facility described below that is covered under the Center of Excellence for Transplants Program, The Empire Plan will be considered the enrollee's primary coverage for purposes of this section. The enrollee or the enrollee's primary health plan must send the denial letter to the Hospital Program administrator. For assistance with this process, contact The Empire Plan and choose the Hospital Program.

Types of transplants

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

- Bone marrow
- Cord blood stem cell
- Heart
- Heart-lung
- Kidney
- Liver
- Lung
- Pancreas
- Pancreas after kidney
- Peripheral stem cell
- Simultaneous kidney/pancreas

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

Centers of Excellence

Facilities covered under the Center of Excellence for Transplants Program include:

- BlueCross and BlueShield Association's Blue Quality Centers for Transplant (BQCT), a national network of transplant providers with demonstrated success in achieving positive outcomes.
- Facilities in New York State that have been identified by the Hospital Program administrator for their excellence in kidney transplantation.

What is covered

You receive paid-in-full benefits for the following services:

- Pretransplant evaluation.
- Inpatient and outpatient hospital and physician care related to the transplant, including 12 months of follow-up care at the center where the transplant was performed. The 12-month period begins on the date of your transplant.

Preauthorization



To receive the paid-in-full benefit and the travel benefit, you must call The Empire Plan and choose the Hospital Program to preauthorize the covered services. To enroll in the Program and receive these benefits, The Empire Plan must be your primary coverage.

Other benefits still available

Since the Center of Excellence for Transplants Program is voluntary, you are still eligible for Empire Plan benefits for your medically necessary transplant if you do not use the Program. However, you will have to comply with the requirements of the Benefits Management Program and will have to pay any applicable deductible, coinsurance and copayments. **You must call the Hospital Program administrator for preadmission certification of admissions for any transplant.**

Infertility Benefits

For the purposes of this benefit, infertility is defined as a condition in which an individual is unable to achieve a pregnancy because the individual and/or partner has been diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but has been unable to carry a fetus to full term.

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. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures.

What is covered

Covered services and supplies include, but are not limited to:

- Artificial/intra-uterine insemination.
- Inpatient and/or outpatient surgical or medical procedures, performed in the hospital, that would correct malfunction, disease or dysfunction resulting in infertility or enhance reproductive capability.
- Services in relation to diagnostic tests and procedures necessary:
 - To determine infertility or
 - In connection with any surgical or medical procedures to diagnose or treat infertility.

The covered diagnostic tests and procedures include hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post-coital tests, testis biopsy, semen analysis, blood tests, ultrasound and other medically necessary diagnostic tests and procedures, unless excluded by law.

The Hospital Program will not exclude coverage for medically necessary care for the diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.

Additional infertility benefits

Additional infertility benefits called Qualified Procedures (specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility) may be available under the Medical/Surgical Program.



You must call The Empire Plan and select the Medical Program for prior authorization for Qualified Procedures.

Certain procedures, called Qualified Procedures, obtained in the inpatient or outpatient departments of a hospital, are covered under the Hospital Program portion of this *Certificate* only if you call in advance and receive prior authorization. If the Medical/Surgical Program administrator authorizes the Qualified Procedures, the following are covered:

- Assisted reproductive technology (ART) procedures including:
 - In vitro fertilization and embryo placement
 - Gamete intra-fallopian transfer (GIFT)
 - Zygote intra-fallopian transfer (ZIFT)
 - Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
 - Assisted hatching
 - Microsurgical sperm aspiration and extraction procedures, including:
 - Microsurgical epididymal sperm aspiration (MESA)
 - Testicular sperm extraction (TESE)
- Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of sperm or embryos).

Maximum lifetime benefit

Benefits paid for Qualified Procedures under The Empire Plan are subject to a lifetime maximum of \$50,000 per covered individual. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures.

Infertility: Exclusions and limitations

Charges for the following expenses are not covered or payable:

- Experimental infertility procedures. (Infertility procedures performed must be accepted as nonexperimental by the American Society of Reproductive Medicine.)
- Fertility drugs prescribed in conjunction with assisted reproductive technology and dispensed by a retail pharmacy are not covered under this benefit. **Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under The Empire Plan.**
- Medical expenses or other charges related to genetic selection.
- Medical expenses or any other charges in connection with surrogacy.
- Any donor compensation or fees charged in facilitating a pregnancy.
- Any charges for services provided to a donor in facilitating a pregnancy.
- 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.
- Psychological evaluations and counseling. **See Section IV: The Empire Plan Mental Health and Substance Abuse Program Certificate of Insurance for coverage that may be provided for psychological evaluations and counseling.**

Other exclusions and limitations that apply to this benefit are included under *What is not covered* in the *Limitations and exclusions* section below.

Centers of Excellence Travel Allowance

When you enroll in the Center of Excellence for Transplants Program or are preauthorized for infertility benefits, you will not have to make any copayments for services performed at a qualified Center of Excellence. A travel, lodging and meal expenses benefit is available to you for travel within the United States. The travel and meals benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, the benefit will include coverage for up to two travel companions. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. 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, taxi or bus fare; shuttle; parking; and tolls.

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

Hospital Program General Provisions

Limitations and exclusions

What is not covered

You are not covered by the Hospital Program for benefits for hospitalization or related expenses described in *Inpatient Hospital Care* (page 14), *Outpatient Hospital Care* (page 16), *Skilled Nursing Facility Care* (page 18), *Hospice Care* (page 19), *Center of Excellence for Transplants Program* (page 21) or *Infertility Benefits* (page 22), when any of the following apply to you:

- A. **Care Received Prior to Your Coverage Under The Empire Plan.** Payment will not be made for services or supplies provided to you before you became covered under The Empire Plan.
- B. **Care, Services or Supplies That Are Not Medically Necessary.** The Hospital Program requires that the service or care you receive be medically necessary. Medically necessary care is care that, according to the Program administrator's criteria, is:
 - Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury.
 - In accordance with generally accepted medical practices.
 - Not solely for your convenience, or that of your doctor or other provider.
 - The most appropriate supply or level of service that can be safely provided to you.

Examples of unnecessary care are:

- When you are admitted to a hospital for care that could have been provided in a doctor's office.
- When hospital care was provided without admission to a hospital as a bed patient.
- When you are in a hospital for longer than is necessary to treat your condition.
- When hospitalized, you receive ancillary services not required to diagnose or treat your condition.
- When the care is provided in a more costly facility or setting than is necessary.
- When a surgical procedure is performed when a medical treatment would have achieved the desired result.

In these situations, the Hospital Program administrator's determination of medical necessity will be made after considering the advice of trained medical professionals (which may include physicians)

who will use medically recognized standards and criteria. In making the determination, the Program administrator will examine all of the circumstances surrounding your condition and the care provided, including your doctor's reasons for providing or prescribing the care, and any unusual circumstances.

The fact that your doctor prescribed the care does not automatically mean that the care qualifies for payments under this Plan.

However, if an external appeal agent, in accordance with the external appeal provisions under *Appeals*, page 35, overturns the Hospital Program administrator's determination that care was medically unnecessary, then the Program administrator will cover the hospitalization or related expense to the extent that the hospitalization or related expense is otherwise covered under this *Certificate*.

- C. **Eye and Hearing Care.** Payment will not be made for eyeglasses, contact lenses or hearing aids and examinations for the prescription or fitting of those items.
- D. **Cosmetic Surgery.** Payment will not be made for services in connection with elective cosmetic surgery that is primarily intended to improve your appearance. However, payment will be made for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the part of the body involved. For a child covered under The Empire Plan, payment will also be made for reconstructive surgery because of congenital disease or anomaly (structural defects at birth) that has resulted in a functional defect.
- E. **Custodial Care.** Payment will not be made for services rendered in connection with a hospital stay or a portion of a hospital stay in connection with physical check-ups, custodial or convalescent care, rest cures or sanitarium-type care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.
- F. **Workers' Compensation.** Payment will not be made for care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. **Payments will not be made even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.** Also, payments will not be made even if you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar legislation.
- G. **Veterans' Facility.** Payment will not be made for services provided in a veterans' facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under The Empire Plan were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service-connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.
- H. **War.** Payment will not be made for services for care of illness or injury due to war, declared or undeclared, that occurs after December 5, 1957.
- I. **Free Care.** Payment will not be made for any care if the care is furnished or would normally be furnished to you without charge. You are not covered for services rendered by a provider for which no legally enforceable charge is incurred.
- J. **Medicare.** Payment will be reduced by the amount available to you under the federal government's Medicare program. **When eligible for primary Medicare coverage, you must enroll in Medicare and file for all benefits available to you under Medicare.** Refer to *If You Qualify for Medicare*, page 29, for further information.
- K. **No-Fault Automobile Insurance.** Payment will not be made for any service covered by mandatory automobile no-fault benefits. However, services not covered under no-fault, such as when there is a deductible, will be covered by the Hospital Program.

L. **Experimental/Investigative Procedures.** The Hospital Program will not cover any treatment, procedure, drug, biological product or medical device (hereinafter “technology”) or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

- Not of proven benefit for the particular diagnosis or treatment of your particular condition or
- Not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

The Hospital Program will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the diagnosis or treatment of your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for the diagnosis or treatment of your particular condition.

The Hospital Program administrator may apply the following criteria in exercising its discretion and may, in its discretion, require that any or all of the criteria be met:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an investigational device exemption or an investigational new drug exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the criteria be met.
- Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined earlier, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- Empire Plan benefits have been paid or approved by the Medical/Surgical Program administrator for the technology based on a determination that the technology is covered under The Empire Plan.

This exclusion does not apply to cancer drugs as required by Section 4303(q) of the New York State Insurance Law.

Experimental/investigational procedures shall also be covered when approved by an external appeal agent in accordance with an external appeal. See the external appeal provisions under *Appeals*, page 35. If the external appeal agent approves coverage of an experimental or investigational procedure, only the costs of services required to provide the procedure to you according to the design of the clinical trial will be covered. Coverage will not be provided for

the costs of investigational drugs or devices, the costs of nonhealth-care services, 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.

- M. **Mental or Nervous Condition or Substance Abuse, Including Alcoholism.** The Hospital Program administrator will not pay for diagnostic services or care associated with mental and nervous conditions or treatment of alcoholism in the following settings:
- Inpatient hospital
 - Day or night centers
 - Outpatient department of a hospital
 - Skilled nursing facility
 - Home care
 - Ambulance service
- N. **Home Care.** The Hospital Program will not pay for home health care services, including home nursing, home infusion therapy and home health aides. The Program will not pay for the following services or supplies provided outside a hospital or skilled nursing facility: physical, occupational and speech therapy; prescription drugs; and laboratory services. Exception: Home health benefits are available under circumstances outlined under *Inpatient Hospital Care*, item Q., page 15.
- O. **Autologous and Directed Blood Donations.** The Hospital Program will not pay for services rendered in connection with the drawing, processing, disposal and/or storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee's own use unless it is medically documented to the satisfaction of the Program administrator that the enrollee's condition requires the use of autologous or directed blood.
- P. **Preventable Adverse Events and Conditions.** The Hospital Program will not pay for services related to events or errors in medical care that are clearly identifiable, preventable and serious in their consequences. The enrollee will not be responsible for these expenses:
- Preventable adverse events including foreign object retained after surgery, surgery performed on the wrong patient, wrong surgical procedure performed or surgery performed on the wrong body part.
 - Preventable conditions including stage III and IV pressure ulcers, catheter-associated urinary tract infections, surgical site infections, manifestations of poor glycemic control, deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

Please refer to the instructions under *Appeals*, page 35, if you wish to appeal a total or partial denial of your claim.

Coordination of Benefits (COB)

Which plan pays first

If you are covered by an additional group health insurance program (such as through your spouse's employer), The Empire Plan will coordinate benefit payments with the other program. In this case, one program pays its full benefit as the primary coverage, and the other program pays secondary benefits. This prevents duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge.

The Empire Plan does not coordinate benefits with any health insurance policy that you or your dependent carries on a direct-pay basis with a private plan.

The procedures followed by the Hospital Program when Empire Plan benefits are coordinated with those provided under another program are as follows:

A. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payments under The Empire Plan and under another plan are not more than the actual charge for a service covered under both group plans.

B. Definitions

- **Plan** means a plan that provides benefits or services for or by reason of hospital, medical or dental care and that is one of the following:
 - A group insurance plan.
 - A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium.
 - A self-insured or noninsured plan.
 - Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization.
 - A group service plan.
 - A group prepayment plan.
 - Any other plan that covers people as a group.
 - A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.
- **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan that reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts that do not.

- C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the actual charge for the service you receive.
- D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a coordination of benefits or similar provision with the same order of benefit determination as stated in item E. and under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.
- E. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules that applies:
1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent.
 2. When this Plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are not divorced or separated (for coverage of a dependent of parents who are divorced or separated, see item 3.):
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year but
 - If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time.

- If the other plan does not have the rule described in the preceding two subparagraphs, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child.
 - Then, the plan of the spouse of the parent with custody of the child.
 - Finally, the plan of the parent not having custody of the child.
 - If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.
 4. The benefits of a plan that covers a person as an employee or as the dependent of an employee who is neither laid off nor retired are determined before those of a plan that covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule (4.) is ignored.
 5. If none of the rules in 1. through 4. determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.
- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
 - G. Any information about covered expenses and benefits needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.
 - H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
 - I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts considered proper under this provision.

When The Empire Plan is secondary to another insurance plan

If a provider receives prior approval to provide services from the plan providing primary coverage, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the plan providing primary coverage has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the *Certificate* language.

If You Qualify for Medicare

Your Empire Plan Hospital Program coverage changes when you become eligible for primary coverage under Medicare.

If you or your enrolled dependent is eligible for Medicare at age 65, or because of disability or end-stage renal disease, refer to the *General Information Book* for information on which plan provides your **primary** coverage.

If you are eligible for primary coverage under Medicare—even if you fail to enroll—your covered hospital and medical expenses will be reduced by the amount that would have been paid by Medicare, and the Hospital Program will consider the balance for payment under the terms of The Empire Plan.

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization (HMO) under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances.

A. Retired Employees and/or Their Dependents 65 Years of Age and Older.

- **General.** If you are eligible for Medicare, you must enroll in both Part A (hospitalization and skilled nursing facilities) and Part B (medical services and supplies) of Medicare. **If you are not eligible for Part A of Medicare, you must still enroll in Part B.** You may enroll in Medicare by applying at your local Social Security office.
- **Medicare and Your Empire Plan Hospital Program Coverage.** The Empire Plan Hospital Program will pay for the following benefits that are not paid for by Medicare:
 - The initial deductible in each spell of illness.
 - The coinsurance amount for the 61st through the 90th day of hospital care in each spell of illness.
 - After you have used the 90 days of hospital care paid for by Medicare, the Empire Plan Hospital Program will pay for additional days of inpatient care in each spell of illness, until Medicare and the Hospital Program have together paid for a total of 365 days of care.

You also have 60 Medicare reserve days in your lifetime. Each reserve day requires a copayment. You may use the reserve days at any time, including after the 90th hospital day when you are using what remains of your 365 Empire Plan Hospital Program benefit days. If you use your Medicare reserve days and Empire Plan Hospital Program benefit days at the same time, the Empire Plan Hospital Program will pay only the copayment. However, each day for which the Hospital Program pays, only the copayment applies against the 365-day maximum. Therefore, it is to your advantage to use the reserve days after you have used your 365 Empire Plan Hospital Program benefit days. Refer to *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance* for information on using your Medical/Surgical Program coverage and Medicare reserve days.

All of the other benefits provided by the Empire Plan Hospital Program under this Plan become available to you after you have exhausted any benefits available to you under Medicare, except for care in a skilled nursing facility.

- **Payment of Medicare Claims.** When admitted to a hospital, always show your Empire Plan Benefit Card and your Medicare Identification Card. The hospital will then file claims with Medicare and the Empire Plan Hospital Program. You should not be billed for any charges covered under either of these programs.

If the hospital does not deal directly with the Empire Plan Hospital Program administrator, submit the Explanation of Benefits form you received from Medicare to the Empire Plan Hospital Program administrator. Covered expenses will then be processed for payment. See *Filing and Payment of Hospital Claims*, page 33, to find out which plan should receive the claim.

Remember: Bills go to Medicare, then to the Empire Plan Hospital Program administrator.

For more information on Medicare benefits and claims, call Medicare or check the website (see *Contact Information*, page 131).

- B. Active Employees and/or Their Dependents.** If you are an active employee or the dependent of an active employee (except for a domestic partner eligible for Medicare due to age), regardless of age, you automatically have full coverage under this Plan unless you elect in writing to make Medicare your primary coverage. In that case, your coverage under this Plan will terminate.

These benefits will be supplemented by those benefits under Medicare for which you have enrolled. Call your local Social Security office for information on how to file a claim for these supplemental benefits.

Note for domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65 and if the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary. Contact your personnel office or refer to the *General Information Book* for further information.

- C. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.
- D. **End-Stage Renal Disease.** For those eligible for Medicare due to end-stage renal disease, NYSHIP will be the primary coverage for the first 30 months of treatment, then Medicare becomes primary. See *End-stage renal disease* in the *General Information Book*. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.
- E. **Veterans' Facilities.** If you are eligible for primary coverage under Medicare, and you receive treatment in a U.S. Department of Veterans' Affairs facility or other facility of the federal government that is not eligible for payment from Medicare, The Empire Plan will pay as a secondary coverage, not primary coverage. The Empire Plan payment will be calculated as if the services were provided by a nongovernmental facility and covered under Medicare. You are not responsible for the cost of services in a governmental facility if those expenses would have been covered under Medicare.

Termination of Your Empire Plan Hospital Program Coverage

- A. **Termination of Eligibility.** Your coverage under this Plan terminates when you are no longer eligible for NYSHIP coverage. Eligibility for coverage is determined under Regulations of the President of the New York State Civil Service Commission. Refer to your *General Information Book* for further information concerning eligibility.

Under certain conditions, you may be eligible to continue coverage under this Plan. Refer to your *General Information Book* for information concerning this eligibility.

Your coverage will also terminate if you fail to make your premium payments toward the cost of The Empire Plan, if any are required.

- B. **Termination of This Plan.** If this Plan ends, your coverage will end.
- C. **Benefits After Termination.** If you are totally disabled on the date coverage ends on your account, the Hospital Program administrator will pay benefits for covered expenses to treat the illness, injury or pregnancy that caused the total disability, on the same basis as if coverage had continued without change, until the date you are no longer totally disabled or up to 12 months from the date your coverage ended, whichever is earlier. This does not apply if the services are covered under another group health plan or Medicare.

In no event will you be entitled to receive greater Hospital Program benefits, or Hospital Program benefits for a longer period of time, than you would have been entitled to receive if your coverage had not terminated.

Call the Hospital Program administrator if you need more information about benefits after termination of coverage.

Miscellaneous Provisions

- A. **No Assignment.** You cannot assign any benefits or monies due from the Hospital Program administrator to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or organization of your right to the services provided or your right to collect from the Program administrator for those services.
- B. **Your Medical Records.** In order to process your claims, it may be necessary for the Hospital Program administrator to obtain your medical records and information from hospitals, skilled nursing facilities, doctors, pharmacists or other practitioners who treated you. When you become covered under this Plan, you automatically give the Program administrator permission to obtain and use those records and that information for the purposes of payment and the administration of health care operations. That permission extends to the physicians and other health care personnel with whom we contract to assist us in administering this Plan and reviewing the medical necessity of services covered under this Plan. If we are unable to obtain the medical records, we have the right to deny payment for that claim. The information will be kept confidential.
- C. **Recovery of Overpayments and Subrogation.**

Recovery of Overpayments. On occasion, a payment will be made to you when you are not covered under this Plan, or for a service that is not covered, or in an amount that is more than proper. When this happens, the problem will be explained to you and you must return the amount of the overpayment within 60 days after receiving notification.

Right to Offset. If the Hospital Program makes a claim payment to you or on your behalf or you owe the Program money, you must repay the amount owed. Except as otherwise required by law, if the Hospital Program owes you a payment for other claims received, the Program has the right to subtract any amount owed by you from any payment owed to you.

Subrogation and Reimbursement. These paragraphs apply when another party (including another insurer) is, or may be found to be, responsible for your injury, illness or other condition and the Program has provided benefits related to that injury, illness or other condition. As permitted by applicable state law (unless preempted by federal law), the Hospital Program may be subrogated to all rights of recovery against such party (including your own insurance carrier) for the benefits provided to you under this *Certificate*. Subrogation means that the Hospital Program has the right (independently of you) to proceed directly against the other party to recover the benefits the Program provided.

Subject to applicable state law (unless preempted by federal law), the Program may have the right to reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness or condition for which the Hospital Program provided benefits. Under Section 5-335 of the New York General Obligations Law, the Program's right of recovery does not apply when a settlement is reached between a plaintiff and a defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that you did not take any action against the Program's rights or violate any contract between you and the Program. The law presumes that the settlement between you and the responsible party does not include compensation for the cost of health care services for which the Hospital Program provided benefits.

The Hospital Program requests that you notify them within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or to obtain compensation due to an injury, illness or condition sustained by you for which the Hospital Program provided benefits.

You must provide all information requested by the Program or the Program's representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Program reasonably requests.

- D. **Right to Develop Guidelines.** The Hospital Program administrator reserves the right to develop or adopt criteria that set forth in more detail the instances and procedures when they will make payment.

Examples of the use of the criteria are to determine whether hospital inpatient care was medically necessary or whether emergency care in the outpatient department of a hospital was necessary. If you have a question about the criteria that apply to a particular benefit, you may contact the Program administrator and you will receive an explanation of these criteria.

- E. **Time to Sue.** You must start any lawsuit against the Hospital Program administrator within two years from the date on which the Program administrator issued the initial notification that benefits were not available.

Filing and Payment of Hospital Program Claims

- A. **Identification Card.** When you receive hospital services, show your Empire Plan Benefit Card. The hospital will contact Empire BlueCross BlueShield for payment. If you receive hospital services outside of New York State, have the hospital submit its bills to the local BlueCross plan and instruct the local BlueCross plan to refer the bill to Empire BlueCross BlueShield, Code YLS (see *Contact Information*, page 129, for more details).

If you are over age 65, or otherwise eligible for Medicare, see *Payment of Medicare Claims* in the *If You Qualify for Medicare* section, page 30, for the payment of Medicare claims.

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

- For services in the United States, the bill is payable to the hospital unless you have already paid the bill. Then, Empire BlueCross BlueShield will reimburse you for covered services.
- For services outside of the United States, Empire BlueCross BlueShield will pay you directly.

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

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, and your Empire Plan identification number to the address listed in the *Contact Information* section, page 129.

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.

- C. **If Empire BlueCross BlueShield Denies Your Claim for Benefits.** If Empire BlueCross BlueShield denies your claim for benefits for a medical procedure or service on the basis that the medical procedure or service is not medically necessary, benefits will be paid by Empire BlueCross BlueShield for covered hospitalization and related expenses if:
- Another Empire Plan Program administrator has liability for some portion of the expenses for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service or
 - Another Empire Plan Program administrator has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written preauthorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the preauthorization and
 - You provide to Empire BlueCross BlueShield proof of payment or preauthorization of benefits from the other Empire Plan Program administrator regarding the availability of Empire Plan benefits to you for that medical procedure or service.

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

Utilization Review Guidelines

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

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

Concurrent reviews

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

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

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

Retrospective reviews

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

Notice of adverse determination

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

Appeals

You or another person acting on your behalf may submit an appeal. If a post-service claim (a claim for benefits payment after medical care has been received) or a preservice request for benefits (including a request for benefits that requires notification, precertification or benefit confirmation prior to receiving medical care) is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal by writing to the address listed in the *Contact Information* section, page 129. Or, call The Empire Plan and choose the Hospital Program.

Appeal process

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

Level 1 appeals

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

For a first-level appeal of a post-service claim, the appeal will be reviewed and within 30 days of your request, the Program administrator will provide you with a written decision.

For a first-level appeal of a preservice request for benefits, the appeal will be reviewed and within 15 days of your request, the Program administrator will provide you with a written decision.

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

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

Level 2 appeals

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

For a second-level appeal of a post-service claim, the appeal will be reviewed and within 30 days of your request, the Program administrator will provide you with a written decision.

For a second-level appeal of a preservice request for benefits, the appeal will be reviewed and within 15 days of your request, the Program administrator will provide you with a written decision.

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

Appeals involving urgent situations

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

If you are unable to resolve a problem with an Empire Plan Program administrator, you may contact the Consumer Assistance Unit of the New York State Department of Financial Services at the address listed in the *Contact Information* section, page 131.

External appeals

Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Hospital Program administrator has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal for review of that decision by an external appeal agent, an independent entity certified by the New York State Department of Financial Services to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary

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

- 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 previously and, if any new or additional information regarding the service or procedure was presented for consideration, the Hospital Program administrator must have upheld the denial or you must both agree in writing to waive any internal appeal.

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

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

- The service must otherwise be a covered service under the Policy.
- You must have received a final adverse determination through the internal appeal process described previously and, if any new or additional information regarding the service or procedure was presented for consideration, the Hospital Program administrator must have upheld the denial or you must both agree in writing to waive any internal appeal.

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

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

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation. Your attending physician should contact the New York State Department of Financial Services [see *Contact Information*, page 131] to obtain current information about what documents will be considered acceptable).
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

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

Your right to appeal that a service should be covered because it is considered a rare disease

A rare disease is defined as a condition:

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

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

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

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

The external appeal process

If, through the internal appeal process described previously, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four months from receipt of such notice to file a written request for an external appeal. If you and the Hospital Program administrator have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. The Program administrator will provide an external appeal application with the final adverse determination issued through the Program administrator's internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services (see *Contact Information*, page 131). Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Hospital Program administrator based its denial, the external appeal agent will share this information with the Program administrator in order for the Program administrator to exercise its right to reconsider its decision. If the Program administrator chooses to exercise this right, it will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), the Program administrator does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or the Hospital Program administrator. If the external appeal agent requests additional information, it will have five additional business days to make a decision. The external appeal agent must then notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Program administrator by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision. If the external appeal agent overturns the Program administrator's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Program administrator will provide coverage subject to the other terms and conditions of the Policy.

Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Program administrator will only cover the costs of services required to provide treatment to you according to the design of the trial. The Hospital Program administrator shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth-care services, the costs of managing research or costs that would not be covered under the Policy for nonexperimental or noninvestigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Program administrator. The external appeal agent's decision is admissible in any court proceeding.

You will be charged a fee of \$25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. The Program administrator will also waive the fee if it is determined that paying it would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an external appeal

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

Four-month external appeal deadline

Under New York State law, your completed request for external appeal must be received by the Department of Financial Services within four months (with an additional eight days allowed for mailing) of the date of the final notice of adverse determination of the first-level appeal or the date upon which you receive a written waiver of any internal appeal. The Hospital Program administrator has no authority to grant an extension of this deadline.

Where to Get More Detailed Information

If this book does not answer the questions you may have about your Empire Plan Hospital Program coverage, contact your Health Benefits Administrator (HBA). If your HBA is unable to answer your questions about your coverage, then contact the Hospital Program administrator (see *Contact Information*, page 128) or call The Empire Plan.

If you are unable to obtain the information you need, or if you are a retired State employee, you may contact the New York State Department of Civil Service (see *Contact Information*, page 132).

Section III: The Empire Plan

Medical/Surgical Program Certificate of Insurance

The Empire Plan includes the Participating Provider Program, the Basic Medical Program, the Home Care Advocacy Program (HCAP), the Managed Physical Medicine Program, Infertility Benefits and the Center of Excellence for Cancer Program. The following describes these programs.

The Empire Plan was designed to provide you with comprehensive medical care coverage in such a way as to curb rising health care costs. To receive the highest level of benefits, be sure you understand each of these programs.

Plan Overview

Medical coverage for most services is under the Participating Provider Program and the Basic Medical Program (covering nonparticipating providers). The following information will give you an overview of how these two parts work to provide benefits for covered services.

If you choose a participating provider

You pay only the copayment for covered services. (Some services require no copayment.)

If you choose the Basic Medical Program (a nonparticipating provider)

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. Please do not send claims to the Medical/Surgical Program administrator until the annual deductible is satisfied.

Once the annual deductible is satisfied, submit claims to the Program administrator. The Empire Plan reimburses you 80 percent of the reasonable and customary charges 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 you and your family meets the coinsurance maximum. You also pay any charges above the reasonable and customary amount.

Note: There are also five special programs under your Medical/Surgical Program coverage: the Home Care Advocacy Program (HCAP) for home care services and durable medical equipment and supplies, the Managed Physical Medicine Program for chiropractic treatment and physical therapy, the Basic Medical Provider Discount Program, the Infertility Benefits Program and the Center of Excellence for Cancer Program. Special benefits and requirements apply under these programs, as explained in each section.

Participating providers

Participating providers have agreed to accept a schedule of allowances, including any copayment, for their services. When you use a participating provider, you pay the provider your copayment for covered services and the Medical/Surgical Program administrator pays the provider in accordance with the schedule of allowances. You do **not** have to pay the participating provider for remaining charges for covered services or submit a claim form. You sign a claim form, the provider sends it to the Medical/Surgical Program administrator and the Program sends you an Explanation of Benefits form telling you what benefits the participating provider received.

Using participating providers is convenient for you and helps keep the cost of The Empire Plan at a reasonable level.

Basic Medical (nonparticipating providers)

The second portion of this Plan is the **Basic Medical Program**. When you use a nonparticipating provider, you are responsible for paying the provider's charges, and must submit a claim for benefits due to you. You are liable for an annual deductible, for a percentage of covered medical expenses in excess of the deductible, for any charges above the reasonable and customary amount and for any penalties incurred under the Benefits Management Program. See *How, When and Where to Submit Claims*, page 72, for information about how to submit Basic Medical claims.

The Benefits Management Program requirements apply if The Empire Plan is primary

Please refer to *Section I: The Empire Plan Benefits Management Program*. Make sure you understand the steps you must take for each program in order to receive maximum benefits.

Your benefits under both the Participating Provider Program and the Basic Medical Program can be affected by the requirements of the Benefits Management Program.

Meaning of Terms Used

Throughout this *Certificate*, the meaning of these terms is limited to these definitions:

- A. **This Plan** means the medical expense coverage described in this plan document and any subsequent amendments, which is self-insured by the New York State Department of Civil Service and for which UnitedHealthcare Insurance Company of New York is the administrative services provider.
- B. The word **You** as used in this Plan means you, the enrollee, and you, an eligible dependent member of the enrollee's family. **Enrollee** and **Dependent** are defined in the *General Information Book*.
- C. **Provider** means a practitioner licensed and/or certified and qualified under his or her respective scope of license under applicable state law to perform a covered medical service. Providers include, but are not limited to, audiologists, certified midwives, chiropractors, dentists, licensed nurse practitioners, nurses, optometrists, pathologists, physical therapists, physicians and speech therapists. Provider also means facilities legally licensed to perform a covered medical service, including, but not limited to, convenience care clinics, dialysis centers, laboratories and outpatient surgical centers.
- D. **Hospital** is defined in the Hospital Program section of this book.
- E. **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 63.

Home Care Advocacy Program (HCAP) Providers are those eligible providers who have an agreement in effect with the Medical/Surgical Program administrator to provide home nursing services, home infusion therapy and/or durable medical equipment or supplies under HCAP.

- F. **Schedule of Allowances** means the Medical/Surgical Program administrator's schedule of amounts it will pay to Empire Plan participating providers for covered medical services.
- G. 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. **The fees charged by a nonparticipating provider may exceed the amount reimbursed by the Program administrator.**

- H. **MPN Network Providers** are those eligible providers who have an agreement in effect with Managed Physical Network, Inc., (MPN) to accept your copayment plus the MPN network allowance as payment in full for chiropractic treatment and physical therapy under the Managed Physical Medicine Program.
- I. **MPN Network Allowance** means the amount Managed Physical Network, Inc., (MPN) network providers have agreed to accept as payment in full for services they render to you, including your copayments, under the Managed Physical Medicine Program.
- J. An **MPN Non-Network Provider** is one who has not entered into an agreement with Managed Physical Network, Inc., (MPN) to accept payment in accordance with the MPN network allowance under the Managed Physical Medicine Program for chiropractic treatment or physical 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. **The fees charged by a non-network provider may exceed the amount reimbursed by the Medical/Surgical Program administrator.**
- K. **HCAP Network Allowance** means the amount Home Care Advocacy Program (HCAP) network providers have agreed to accept as payment in full for services they render to you.
- L. **HCAP Non-Network Allowance** means the lower of the following:
- The amount you actually paid for a medically necessary service, equipment or supply covered under the Home Care Advocacy Program (HCAP).
 - 50 percent of the HCAP network allowance for such service, equipment or supply.
- The HCAP non-network allowance for a home care service, durable medical equipment or supply is determined by the Medical/Surgical Program administrator and 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.
- M. An **HCAP Non-Network Provider** is one who has **not** entered into an agreement with the Medical/Surgical Program administrator to accept payment in accordance with the HCAP network allowance under the Home Care Advocacy Program. You are responsible for paying a non-network provider's charge. To receive reimbursement for such charges, you must file a claim with the Program administrator. **The fees charged by a non-network provider may exceed the amount reimbursed by the Program administrator.**
- N. **Medically Necessary** or **Medical Necessity** means the health care services, supplies and pharmaceutical products that are determined by the Medical/Surgical Program administrator to be medically appropriate and:
- Necessary to meet your basic health needs.
 - Rendered in the least intensive and most appropriate setting for the delivery of the service or supply.
 - Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies that are accepted by the Medical/Surgical Program administrator.
 - Consistent with the diagnosis of the condition.
 - Required for reasons other than the comfort or convenience of you or your physician or other provider.
 - Demonstrated through prevailing peer-reviewed medical literature to be either:
 - Safe and effective for treating or diagnosing the sickness or condition for which their use is proposed or

- Safe with promising efficacy:
 - For treating a life-threatening sickness or condition,
 - In a clinically-controlled research setting and
 - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

The fact that a physician or other provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this *Certificate* relates only to coverage and differs from the way in which a physician or other provider engaged in the practice of medicine may define medically necessary.

- O. **Covered Medical Expenses** means the covered charges for covered medical services performed or supplies or pharmaceutical products prescribed by a physician or other provider, except as otherwise provided below, due to your sickness, injury or pregnancy. A covered medical expense is incurred on the date the service, supply or pharmaceutical product is received by you. In order for a charge to be a covered medical expense, the service, supply or pharmaceutical product must be provided by a provider as defined in item C. on page 41.

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.

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, 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 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 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 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.

P. **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 reasonable and customary charge for a service or supply is made by the Medical/Surgical Program administrator. In making the determination of the reasonable and customary charge 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.

You are responsible for any amount billed by a nonparticipating provider that exceeds the reasonable and customary charge, in addition to the annual deductible and coinsurance amounts.

Q. **Combined Annual Deductible** means the amount you must pay in total, each calendar year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program (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 \$1,000 for the enrollee, \$1,000 for the enrolled spouse/domestic partner and \$1,000 for all dependent children combined.

The combined annual deductible must be met before your claims can be reimbursed.

Each \$1,000 deductible will be reduced to \$500 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

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

R. **Calendar Year** means the period beginning with January 1 and ending with December 31.

S. **Coinsurance** means the difference between the reasonable and customary charge or scheduled pharmaceutical amount and the covered percentage under the **Basic Medical** portion of the Plan. Coinsurance also means the difference between the network allowance and the covered percentage under the **Managed Physical Medicine Program** and the **Home Care Advocacy Program (HCAP)**. You pay the coinsurance.

T. **Covered Percentage**

1. Under the Participating Provider Program, the **covered percentage** is **100 percent** of the schedule of allowances, including your copayment.
2. Under the Basic Medical portion of this Plan, the **covered percentage** for covered medical expenses is **80 percent** of the reasonable and customary charge or the scheduled pharmaceutical amount except:
 - a. As provided under *Prospective Procedure Review*, page 6; under the *Home Care Advocacy Program (HCAP)*, page 57; under *Guaranteed access for the Managed Physical Medicine Program*, page 62; and under *Infertility Benefits*, page 63; and
 - b. The **covered percentage becomes 100 percent** of the reasonable and customary charge or the scheduled pharmaceutical amount once the combined annual coinsurance maximum is met.

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

Each \$3,000 coinsurance maximum will be reduced to \$1,500 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, Hospital and Mental Health and Substance Abuse (MHSA) Programs are applied to the combined annual coinsurance maximum. Copayments for participating provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum.

The annual deductible does not count toward the coinsurance maximum. Any expenses above the reasonable and customary charge or the scheduled pharmaceutical amount do not count. Expenses under the Home Care Advocacy Program (HCAP), Managed Physical Medicine Program and the Benefits Management Program do not count toward the coinsurance maximum, nor do any penalties under the Benefits Management Program or HCAP.

Once the combined annual coinsurance maximum is met, covered medical expenses will be reimbursed at 100 percent of the reasonable and customary or scheduled pharmaceutical amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the reasonable and customary or scheduled pharmaceutical amount and any penalties under the Benefits Management Program.

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 reasonable and customary charges. 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 63.

- U. **Outpatient** means that covered medical expenses are incurred in a physician's or other provider's office, in the outpatient department of a hospital or in a hospital extension clinic (an outpatient facility that is hospital owned and is not in the same location as the hospital).
- V. **Inpatient** means covered medical expenses are incurred during confinement for which a room and board charge is made by a hospital.
- W. The **Annual Maximum** for the Basic Medical portion of this Plan is unlimited.
- X. 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 per covered person under the Empire Plan Hospital and Medical/Surgical Programs.
- Y. **Emergency Care** is care received for an emergency condition. An emergency condition is:
 - A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:
 - Placing the health of the person afflicted with such condition, or, with respect to a pregnant woman, the health of the woman and the unborn child in serious jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy,
 - Serious impairment to such person's bodily functions,
 - Serious dysfunction of any bodily organ or part of such person or
 - Serious disfigurement of such person.
 - A condition described in clause (i), (ii) or (iii) of Section 1867(e)(1)(A) of the Social Security Act.
- Z. **Your Copayment** is the first \$20 that you are required to pay for certain services by participating providers and Managed Physical Network, Inc., (MPN) network providers, or the first \$30 in a participating outpatient surgical location.

- AA. An **Urgent Care Center** is a facility staffed by medical professionals that include physicians and nurses, with evening and weekend hours. It provides services for acute and uncomplicated problems without the need for an appointment.
- AB. A **Spell of Illness** begins when you are admitted as a patient to a hospital, birthing center or skilled nursing facility or receive home health care. When you are no longer a patient or receiving home health care for a period of at least 90 days for the same illness, the spell of illness ends, and benefits are available to you again starting with the date of your new spell of illness.
- AC. **Nuclear Medicine** means a subspecialty of radiology best used to demonstrate both image and function of a body organ, as well as its anatomy. It has diagnostic capabilities as well as valuable therapeutic applications and uses very small amounts of radioactive substances, or tracers that are attracted to specific organs, bones or tissues, to diagnose or treat disease.
- AD. **Scheduled Pharmaceutical Amount** means:
 For covered pharmaceutical products, the lowest of:
- The actual charge billed for such covered pharmaceutical product.
 - The average wholesale price of such pharmaceutical product as set forth in the *Red Book* drug pricing resource. The pharmaceutical product pricing information is updated annually on October 1. When *Red Book* does not have a price for the product, the Medical/Surgical Program administrator uses alternative pricing sources such as RJ Health or an internally developed pharmaceutical pricing resource to determine the average wholesale price for the covered pharmaceutical product. The Program administrator will provide specific pricing information to you upon request.
- You are responsible for any amount billed by a nonparticipating provider that exceeds the scheduled pharmaceutical amount, in addition to the combined annual deductible and coinsurance amounts.
- AE. **Pharmaceutical Products** means FDA-approved prescription pharmaceutical products administered by a physician or other provider within the scope of the provider's license. Pharmaceutical products do not include pharmaceuticals that are dispensed to you by a licensed pharmacy, which are subject to the provisions of your Prescription Drug Program.
- AF. A **Convenience Care Clinic** is a health care clinic located in a fixed location in a retail store, supermarket or pharmacy that treats uncomplicated minor illnesses and provides preventive health care services. It is staffed by medical professionals that include physicians, licensed nurse practitioners, physician assistants and nurses and is designed to provide fast, appointment-free health care services.
- Only services received at a participating convenience care clinic are covered; services received at a nonparticipating convenience care clinic are not covered.
- AG. **Preventive Care Services** means routine health care that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems. The federal Patient Protection and Affordable Care Act (PPACA) requires coverage of certain preventive care services received from a participating provider to be paid at 100 percent (not subject to copayment). Preventive care services covered under PPACA include:
- Items or services with an "A" or "B" rating from the United States Preventive Services Task Force.
 - Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
 - Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
 - Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

For further information on preventive care services, see the *Empire Plan Preventive Care Coverage Chart* on NYSHIP Online (see *Contact Information*, page 128), or visit www.hhs.gov/healthcare/rights/preventive-care.

AH. **Program Administrator** means the company contracted by the State of New York to administer the Empire Plan Medical/Surgical Program. The Medical/Surgical Program administrator is UnitedHealthcare. The Program administrator is responsible for processing claims at the level of benefits determined by the Empire Plan and for performing all other administrative functions under the Empire Plan Medical/Surgical Program.

Participating Provider Program

The Participating Provider Program of The Empire Plan is described in this portion of the *Certificate*.

When you use a participating provider, you pay only applicable copayments. Not all services are subject to copayments and you pay a maximum of two copayments per visit for services billed by the same provider:

- One copayment applies to charges for an office visit and/or office surgery.
- One copayment applies to charges for laboratory and/or radiology services provided in the same visit. If a laboratory test and/or radiology test is sent to an outside service, an additional copayment(s) will apply.

Except as noted below, your copayment is \$20. 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.

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

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

Finding participating providers

To learn whether a doctor, specialist, laboratory, outpatient surgical location, cardiac rehabilitation center or urgent care center is an Empire Plan participating provider, check with the provider directly (tell the provider you are in The Empire Plan for New York government employees) or call The Empire Plan and choose the Medical Program. Or, visit NYSHIP Online and check *The Empire Plan Participating Provider Directory* (see *Contact Information*, page 128).

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

When you use a participating provider, the Medical/Surgical Program administrator will pay for the covered medical services listed below. You must advise the participating provider of your Empire Plan coverage **before** you receive services. Benefits are automatically assigned and the Program administrator will pay the participating provider directly in accordance with the schedule of allowances. By using participating providers, you minimize your out-of-pocket expenses.

You have the freedom to choose any participating provider without a referral. However, there is no guarantee a participating provider will always be available to you. **The Empire Plan does not require**

that a participating provider send you to a participating specialist, laboratory, radiologist or center. Ask for a participating provider and ask that samples be sent to a participating laboratory. It is always your responsibility to determine whether a provider is an Empire Plan participating provider.

When you use a nonparticipating provider, covered benefits are payable under the Basic Medical portion of the Plan, so your out-of-pocket expenses are usually higher.

Guaranteed access

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

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

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

Primary Care	Specialist
Urban: 8 miles Suburban: 15 miles Rural: 25 miles	Urban: 15 miles Suburban: 25 miles Rural: 50 miles

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

Primary Care Providers		
Family Practice General Practice	Internal Medicine	Pediatrics Obstetrics/Gynecology
Specialties		
Allergy Anesthesia Cardiology Dermatology Emergency Medicine	Gastroenterology General Surgery Hematology/Oncology Neurology Ophthalmology Orthopedic Surgery	Otolaryngology Pulmonary Medicine Radiology Rheumatology Urology

What is covered under the Participating Provider Program

Under the Participating Provider Program, covered medical expenses include charges for the following services.

- A. **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 (paid in full for enrollees and dependents age 60 or older; subject to copayment for enrollees and dependents age 55 through 59).
- B. **Breast Pumps** – You are covered, not subject to copayment, for purchase of a double-electric breast pump following the birth of your child. This is a network benefit only; you must utilize a Medical/Surgical Program national provider.
- C. **Cardiac Rehabilitation Center** – If your physician prescribes cardiac rehabilitation, you pay a \$20 copayment for each visit to a freestanding cardiac rehabilitation center that has an Empire Plan 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 Empire Plan agreement in effect with the Medical/Surgical Program administrator on the date of your visit.
- D. **Chronic Care** – You are covered for chronic care services for chemotherapy, radiation therapy and dialysis. There is no copayment for these chronic care services or for related services rendered during the course of chemotherapy, radiation therapy or dialysis.
- E. **Contraceptive Drugs and Devices** – When the office visit is solely for the purpose of obtaining such drug or device, including contraceptive drugs and devices dispensed by the provider, the visit is covered, not subject to copayment. The cost of FDA-approved contraceptive methods for women, including sterilization, that require physician intervention, are covered and are not subject to a copayment.
- F. **Dental Care** – You are covered for 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 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. **Diabetes Education Centers** – If you have a diagnosis of diabetes, you are covered for visits for self-management education, subject to an office visit copayment.
- H. **Diagnostic Laboratory and Radiology** – You are covered for diagnostic laboratory and radiology procedures performed as outpatient services. You are also covered for the separate interpretation of radiology procedures by a radiologist if the radiologist bills separately.

If both outpatient diagnostic laboratory tests and outpatient radiology procedures are billed by a participating provider during a single visit, only one copayment will apply.

- I. **Infertility Treatment** – See *Infertility Benefits*, page 63, for information regarding benefits for the treatment of infertility.
- J. **In-Hospital Anesthesia** – You are covered for anesthesia services if such services are performed in connection with 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.

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.

- L. **Mammograms** – In addition to mammograms performed when a medical condition is suspected or known to exist, you are covered for mammograms under these conditions:
 - A single baseline mammogram for covered persons 35 through 39 years of age, subject to copayment.
 - A mammogram every year for covered persons 40 years of age and older, or more frequently upon the recommendation of a physician or other provider. Mammograms performed for routine preventive care are not subject to copayment.
 - Upon the recommendation of a physician or other provider, a mammogram for covered persons at any age having a prior history of breast cancer or who have a first-degree relative with a prior history of breast cancer. A copayment will apply if the covered person is age 39 or younger.
- M. **Mastectomy Bras** – Mastectomy bras, including replacements when functionally necessary, are covered when prescribed by a physician. There is no copayment when you use a participating provider.
- N. **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.

There is no copayment for prenatal visits, delivery and the six-week check-up after delivery.

- O. **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.
- P. **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.

- Q. **Outpatient Surgical Location** – You pay a \$30 copayment for facility charges at a freestanding outpatient surgical location that has an Empire Plan agreement in effect with 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 \$30 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.
- R. **Pediatric Immunizations** – Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and the cost of oral and injectable substances when administered according to pediatric immunization guidelines.
- S. **Podiatry** – You are covered for the services of a podiatrist except for routine care of the feet, subject to copayment.
- T. **Prostheses and Orthotic Devices** – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs. There is no copayment for the prosthesis and/or orthotic device when you use a participating provider. Replacements, when functionally necessary, are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot is covered only when it is medically necessary and custom made.
- 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).
 - 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 \$20 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.
- W. **Specialist Consultations** – A consultation is more extensive than an office visit. A physician may refer you to a specialist for consultation to have your medical condition evaluated and to obtain professional advice regarding how to proceed with your care.

You are covered, subject to copayment(s), for **one out-of-hospital consultation** in each specialty field per calendar year for each condition being treated. You are covered for **one in-hospital consultation** in each specialty field, per confinement, for each condition being treated.

You are **not** covered for consultations in the fields of pathology, radiology or anesthesiology.

Exception: Consultations by an anesthesiologist, not rendered in conjunction with anesthesia services for surgery, such as office consultations for pain management, are covered when medically necessary.

- X. **Speech Therapy** – You are covered, subject to copayment, for the services of a speech therapist or speech-language pathologist when:
- Such services are prescribed and supervised by your physician,
 - Treatment is medically necessary and
 - The provider is currently licensed in the state where the service is rendered.
- 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.
- Z. **Urgent Care Center** – Services received at an urgent care center that has an Empire Plan agreement in effect with the Medical/Surgical Program on the date of your visit are covered, subject to copayment.

Basic Medical Program

If you incur covered medical expenses and do not use a participating provider, your benefits for most services will be determined under the Basic Medical portion of this Plan. This section describes your coverage under the Basic Medical Program, and how the Program works.

Also refer to the sections of this *Certificate* on the *Home Care Advocacy Program (HCAP)*, page 57, and *Managed Physical Medicine Program*, page 62. Benefits for certain services are determined under these Programs, not under the Basic Medical Program.

You may have access through the Empire Plan Basic Medical Provider Discount Program (MultiPlan) to nonparticipating providers who have agreed to discount their charges for covered Basic Medical expenses. Your 20 percent coinsurance may be based on a discounted fee, rather than the reasonable and customary charges, if:

- The Empire Plan is your primary coverage,
- You receive covered Basic Medical services from the nonparticipating provider,
- The discounted fee is lower than the Basic Medical reasonable and customary allowance and
- You have met your combined annual deductible.

You will not be billed for charges in excess of the discounted fee. The provider will submit claims for you and the Medical/Surgical Program administrator will pay the provider directly.

Assignment of Benefits to a Nonparticipating Provider Is Not Permitted: 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.

You must meet a deductible and pay 20 percent coinsurance when you choose nonparticipating providers

You are responsible for the charges billed by a nonparticipating provider, and must submit a claim for benefits due. These benefits are calculated based on the following:

- First, you are liable for the combined annual deductible. It is your responsibility.
- After the deductible, covered medical expenses are considered for payment. The Medical/Surgical Program administrator will reimburse you for 80 percent of the reasonable and customary charges for covered services and supplies or the scheduled pharmaceutical amount for pharmaceutical products or actual billed charges, whichever is less. You pay the balance of 20 percent (coinsurance) and any charges above the reasonable and customary or scheduled pharmaceutical amount. The covered percentage becomes 100 percent of the reasonable and customary charge or the scheduled pharmaceutical amount once each combined coinsurance amount exceeds the combined coinsurance maximum in a calendar year.

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

Details of the combined annual deductible (and how it works) and your covered medical expenses are described on the following pages.

A. **Annual Deductible**

The combined annual deductible for covered services supplied by nonparticipating providers is \$1,000 for the enrollee, \$1,000 for the enrolled spouse/domestic partner and \$1,000 for all dependent children combined.

Each \$1,000 deductible will be reduced to \$500 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

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

You must meet the combined annual deductible before your Basic Medical claims can be reimbursed.

B. **Coverage**

The Medical/Surgical Program administrator will pay **Basic Medical benefits** to the extent covered medical expenses in a calendar year **exceed the combined annual deductible and combined annual coinsurance maximum, up to the reasonable and customary charge or the scheduled pharmaceutical amount.**

C. **Covered Basic Medical Expenses**

Covered medical expenses under the Basic Medical Program are defined as the reasonable and customary charge for covered medical services performed or supplies provided by a physician or other provider or the scheduled pharmaceutical amount for pharmaceutical products provided by a physician or other provider, except as otherwise provided below, due to your sickness, injury or pregnancy. These services, supplies and pharmaceutical products must be medically necessary as defined under *Meaning of Terms Used*, item N., page 42. No more than the reasonable and customary charge or the scheduled pharmaceutical amount for medical services, supplies and pharmaceutical products will be covered by this Plan.

Covered medical expenses under the Basic Medical Program are also subject to the definition of covered medical expenses as stated under *Meaning of Terms Used*, item O., page 43.

What is covered under the Basic Medical Program (nonparticipating providers)

Under the Basic Medical Program, covered medical expenses include charges for the following services or supplies:

- 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 \$35. *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.*
- B. **Anesthesiology, Radiology and Pathology** – If you receive anesthesia, radiology or pathology services in connection with covered inpatient or outpatient hospital services at an Empire Plan network hospital and The Empire Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by the Medical/Surgical Program.
- C. **Cardiac Rehabilitation Center** – Medically necessary visits to a cardiac rehabilitation center are covered when prescribed by a physician.
- D. **Dental Care** – You are covered for dental services, including pharmaceutical products and appliances dispensed by a provider:
- For the correction of damage caused by an accident, provided the services, supplies or pharmaceutical products are received within 12 months of the trauma and while you are covered under this Plan.
 - For the correction of damage caused by a medical illness, congenital disease or anomaly for which you are eligible for benefits under this Plan.
 - For charges incurred for temporomandibular joint (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.
- E. **Diabetes Education Centers** – If you have a diagnosis of diabetes, you are covered for medically necessary visits for self-management, subject to deductible and coinsurance.
- F. **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.
- G. **Gynecologic Exams** – You are covered for a minimum of two gynecologic exams each year, as well as any services resulting from such exams.
- H. **Hearing Aids** – Hearing aids, 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.*
- I. **Hospital Emergency Room** – If the Hospital Program administrator determines that you received emergency care in a hospital emergency room, covered charges billed separately by the attending emergency room 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 provided by other specialty physicians or other providers in a hospital emergency room 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, subject to deductible but not coinsurance.
- J. **Hospitals** – Charges for room and board and special services provided to you as an inpatient are covered after Hospital Program benefits have been exhausted.

Remember: You must comply with the requirements of the Hospital and Benefits Management Programs for a hospital admission. Refer to the details of how this Program works in *Section I: The Empire Plan Benefits Management Program*.

If and when it is determined that inpatient care is no longer medically necessary, benefits will cease and notice will be given to the hospital and patient the day before your benefits end.

The Medical/Surgical Program will provide coverage for services and supplies in connection with Infertility Benefits and Cancer Resource Services whether or not benefits are available under the Empire Plan Hospital Program benefits plan.

- K. **Infertility Treatment** – See *Infertility Benefits*, page 63, for information regarding benefits for the treatment of infertility.
- L. **Mammograms:**
- Part of Routine Preventive Care** – You are covered for preventive care mammograms according to the same guidelines that apply under the Participating Provider Program.
- New York State law also provides for an annual mammogram for covered females age 40 and older.
- Part of a Medical Condition** – Mammograms are covered when a medical condition is suspected or known to exist. *This benefit is subject to deductible and coinsurance.*
- M. **Mastectomy Bras** – When prescribed by a physician or other provider, mastectomy bras, including replacements when functionally necessary, are covered, subject to deductible and coinsurance.
- N. **Mastectomy Protheses** – 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). For a prosthesis requiring approval, if a less expensive prosthesis can meet an individual's functional needs, benefits will be available for the most cost-effective choice. *This benefit is not subject to deductible or coinsurance.*
- O. **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.
- P. **Miscellaneous Services and Supplies** – The following services are covered under the Basic Medical Program when not covered elsewhere by the Plan:
- Diagnostic laboratory procedures and radiology.
 - X-ray or radiation treatments.
 - Oxygen and its administration.
 - Anesthetics and their administration, except when performed by your physician or other provider.
 - 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.
 - Adult immunizations provided at non-network pharmacies.
- Q. **Modified Solid Food Products** – When prescribed by a physician or other provider, modified solid food products (MSFP) 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.*
- An MSFP is a product/food that is low in protein or contains modified protein and is consumed by individuals with certain diseases of amino acid and organic acid metabolism.
- R. **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.
- S. **Outpatient Surgical Location** – You are covered for medically necessary facility charges at a freestanding outpatient surgical location.
- T. **Physicians** – Services of physicians and other providers who perform covered medical services are covered.
- U. **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 P. and Q. of the *Exclusions* section under *Medical/Surgical Program General Provisions* (see page 67), are not covered medical expenses.
- V. **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.
- W. **Prosthetic Wigs** are covered up to the \$1,500 lifetime benefit maximum when hair loss is long term and due to a medical condition. These conditions include: disease of the endocrine glands, generalized systemic disease, systemic poisons and hair loss due to radiation therapy, chemotherapy treatment or injury to the scalp. *This benefit is not subject to deductible or coinsurance.*
- Prosthetic wigs are **not** covered when hair loss is due to male or female pattern baldness.
- X. **Reconstructive Surgery** – You are covered for reconstructive surgery under the same conditions as the Participating Provider Program.
- Y. **Routine Health Exams for Active Employees** – Routine health exams are covered for you, the active employee, if you are age 50 or older and for your spouse/domestic partner age 50 or older. *These benefits are not subject to deductible or coinsurance.*
- Z. **Routine Newborn Child Care** – Physician's or other provider's services for routine care of a newborn child are covered. *These benefits are not subject to deductible or coinsurance.*
- AA. **Routine Pediatric Care** – Routine well-child care is covered for children up to age 19, including examinations, immunizations and the cost of oral and injectable substances, according to pediatric care guidelines.
- AB. **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 \$20 copayment you would normally pay for a visit to a participating provider. *This benefit is not subject to deductible.*
- AC. **Specialist Consultations** – Charges for a consultation with a specialist who is a nonparticipating provider are considered under the Basic Medical Program and are subject to your annual deductible and coinsurance.

Basic Medical Benefits are available for **one out-of-hospital consultation** in each specialty field per calendar year for each condition being treated. Basic Medical benefits are available for **one in-hospital consultation** in each specialty field, per confinement, for each condition being treated.

You are **not** covered for consultations in the fields of pathology, radiology or anesthesiology. Exception: Consultations by an anesthesiologist not rendered in conjunction with anesthesia services for surgery, such as office consultation for pain management, are covered when medically necessary.

AD. **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.

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

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

AE. **Urgent Care Center** – You are covered for medically necessary visits to and services provided at an urgent care center.

AF. **Voluntary Sterilization** – Charges for voluntary sterilization are covered medical expenses.

Home Care Advocacy Program (HCAP)

The Home Care Advocacy Program (HCAP) is The Empire Plan program for home care services, durable medical equipment and certain supplies. HCAP is administered by the Medical/Surgical Program administrator.

Read this section carefully for details on how to use HCAP. If you do not use HCAP, you will pay higher out-of-pocket costs.

Network coverage: Paid-in-full benefit



You must call The Empire Plan and choose the Medical Program even if Medicare is primary. You must call The Empire Plan to arrange for services and you must use an HCAP-approved provider to receive paid-in-full benefits under network coverage. You must call HCAP even if Medicare or another plan is primary. If you do not call HCAP before receiving services, you will receive the non-network level of benefits for medically necessary covered services.

If Medicare is your primary coverage and you receive items or services from a Medicare-approved supplier, The Empire Plan will pay the remaining balance after Medicare covers its share of the expense.

Exception: Call the HCAP network provider directly for authorization before receiving diabetic supplies (except insulin pumps and Medijectors) or ostomy supplies. You may contact the HCAP network providers directly at their toll-free numbers. For most diabetic supplies, call the Empire Plan Diabetic Supplies Pharmacy (see *Contact Information*, page 128). (For insulin pumps and Medijectors, you must call HCAP for authorization.) For ostomy supplies, call Byram Healthcare Centers (see *Contact Information*, page 128).

Important Notes:

- If Medicare is your primary coverage, you must use a Medicare contract provider.
- **The Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program:** If you are a Medicare-primary member living in a competitive bidding area and require mail order diabetic testing supplies, or any other items covered under the Program, you must use a Medicare contract supplier. For information regarding the Competitive Bidding Program or to locate a Medicare contract supplier, please contact Medicare (see *Contact Information*, page 131). If you need additional assistance locating a Medicare contract supplier, contact HCAP.

If you do not use a Medicare-approved provider or contract supplier, your benefits will be reduced in accordance with item G. in the *Impact of Medicare on This Plan* section, page 72.

The following home care services and/or durable medical equipment or supplies are covered under HCAP when prescribed by your doctor and determined to be medically necessary by the Medical/Surgical Program administrator.

- **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*, page 60, for coverage of durable medical equipment when you do not use HCAP.

- A. **Durable Medical Equipment** covered under HCAP is medical equipment that is for repeated use and is not a consumable or disposable item, is used primarily for a medical purpose, is appropriate for use in the home and is generally not useful to a person in the absence of a sickness or injury. When appropriate, HCAP benefits are provided for the rental or purchase of durable medical equipment.

Examples of durable medical equipment 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. You will have to call HCAP and HCAP will provide you with the name of an HCAP-approved provider and/or an authorization when necessary.

- 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 and oxygen masks.
- C. **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.

- **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.

Refer to *Non-network benefits*, page 60, 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 Insurance*, item Q., page 15, following early discharge after delivery.

- **Home Infusion Therapy** – You are covered for medically necessary intravenous therapy, such as chemotherapy and pain management, provided by an HCAP participating agency. Care must be prescribed by and under the supervision of a physician. Prescription medications used in therapies such as chemotherapy and 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*.)

- **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.

- **Enteral Formulas** – You are covered for enteral formulas under HCAP. The enteral formula must be prescribed by your physician and medically necessary as determined by HCAP. The prescribed enteral formula must be considered safe and effective for the diagnosis.

Enteral formulas are nutritional replacements taken by mouth or through a feeding tube. These formulas provide basic nutrition intended to be used when food in its usual form is not appropriate or adequate to meet the individual's nutritional needs.

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

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

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

When do requirements apply?

HCAP requirements apply:

- Whenever you seek Empire Plan coverage for home care services and/or HCAP-covered durable medical equipment or supplies.
- Nationwide. You must call HCAP if you live or seek treatment anywhere in the United States.

After you call

Once you call, HCAP will determine to what extent your home care services and/or durable medical equipment or supplies are medically necessary. You will be advised by telephone what services and supplies are precertified and for how long. For ongoing care, the Medical/Surgical Program administrator will also send you a letter of confirmation.

Your benefits and responsibilities under HCAP

The following describes your benefits and responsibilities under HCAP.

Network coverage: When you call HCAP and use an HCAP provider

You have a **paid-in-full** benefit under network coverage when:

- You call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies,
- The Medical/Surgical Program administrator precertifies your home care and/or equipment or supplies as medically necessary and
- The Program administrator makes or helps you make arrangements with an HCAP-approved provider for covered services and/or equipment or supplies.

When you follow these steps, you will have no claim forms and no out-of-pocket cost, no copayment, no deductible and no exclusion for the first 48 hours of skilled nursing.

Non-network coverage: If you do not call or if you call HCAP but do not use an HCAP provider

You will receive **non-network** benefits if:

- You do not call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies or
- You call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies and the Medical/Surgical Program administrator precertifies your home care and/or equipment or supplies as medically necessary but you use a nonparticipating provider that HCAP has not approved for covered services and/or equipment or supplies.

Non-network benefits

If you do not call HCAP for precertification before receiving home care services, durable medical equipment or supplies and/or if you choose to use a non-network provider, you will pay a much higher share of the cost.

48-Hour Exclusion for Skilled Nursing Care: You are responsible for the cost of the first 48 hours of skilled nursing care per calendar year. This is not a covered expense and will not be applied toward your combined annual deductible.

The Combined Annual Deductible Applies: The combined annual deductible for covered services supplied by nonparticipating providers is \$1,000 for the enrollee, \$1,000 for the enrolled spouse/domestic partner and \$1,000 for all dependent children combined.

Each \$1,000 deductible will be reduced to \$500 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

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

You must satisfy the combined annual deductible before non-network benefits will be paid for HCAP-covered services, equipment or supplies.

The amount applied toward satisfaction of the combined annual deductible for non-network HCAP-covered services, equipment and supplies will be the lower of the following:

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

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

Note: Non-network benefits apply to all charges if you don't use HCAP, except that Basic Medical benefits apply to durable medical equipment or supplies that are less than \$100 in total and are dispensed by your doctor during an office visit.

Who calls?

If you cannot call HCAP, others may make the call for you: a member of your family or household, your doctor or a member of your doctor's staff, the hospital, the Benefits Management Program case manager or the Benefits Management Program discharge unit. **But you are responsible for seeing that the call is made.**

Call anytime

When your doctor prescribes home care services, durable medical equipment and certain supplies, call The Empire Plan and choose the Medical Program before you receive services.

In an emergency or urgent situation, obtain necessary care. Then, call HCAP within 48 hours after receiving emergency care or receiving durable medical equipment/supplies. If it is not reasonably possible to call within 48 hours, call HCAP as soon as possible. If HCAP determines that the urgent or emergency care was medically necessary, covered services and/or items will be certified.

Remember, call The Empire Plan and choose the Medical Program before you receive home care services and/or durable medical equipment or supplies. **And call if you have any questions.**

More about HCAP

If You Are Admitted to the Hospital – If you are receiving home care and then are admitted to the hospital, you must call The Empire Plan and choose the Hospital Program before your hospital admission and within 48 hours after an emergency or urgent hospital admission.

Hospice Care – HCAP requirements do not apply to hospice care. Refer to *Hospice Care*, page 19, in *Section II: The Empire Plan Hospital and Related Expenses Certificate of Insurance* for hospice care coverage.

Medical Necessity – If the Medical/Surgical Program administrator determines that you have received home care services and/or durable medical equipment or supplies that were not medically necessary, you must pay the full cost. When HCAP makes or helps you make the arrangements, you are assured that services and equipment or supplies are medically necessary and covered under The Empire Plan.

180-day deadline to appeal

HCAP Appeals – All HCAP appeals are handled directly through HCAP. Submit a written appeal within 180 days of denial of benefits or services to the Medical/Surgical Program administrator (see *Contact Information*, page 128) or call The Empire Plan and choose the Medical Program.

For information on Medical/Surgical Program claim appeals, see *How, When and Where to Submit Claims*, page 72.

Managed Physical Medicine Program

The Managed Physical Medicine Program is administered by Managed Physical Network, Inc., (MPN).

Coverage for chiropractic treatment and physical therapy

Please read this section carefully. You will receive network benefits, the highest level of benefits, when you use MPN network providers for medically necessary chiropractic treatment and physical therapy. You will receive a significantly lower level of benefits when you choose non-network providers.

The Empire Plan Managed Physical Medicine Program covers medically necessary services typically performed by a chiropractor or physical therapist. Other providers, such as osteopaths and occupational therapists, may also provide these services. The provider must be licensed to perform such services in the state where the service is received. Physical therapy must be prescribed by a doctor.

When requirements apply

Managed Physical Medicine Program benefits and responsibilities apply to you and your enrolled dependents whenever you seek coverage for physical therapy or chiropractic treatment, even if you have Medicare or other health insurance coverage as well.

You must follow Program requirements if you seek treatment anywhere in the United States, including Alaska and Hawaii.

Refer to *Section II: The Empire Plan Hospital and Related Expenses Certificate of Insurance* for coverage of physical therapy in a hospital and in the outpatient department of a hospital following related hospitalization or surgery.

Refer to *Home Care Advocacy Program (HCAP)*, page 57, for coverage of physical therapy at home in lieu of hospitalization or care in a skilled nursing facility.

Network benefits

You pay a \$20 copayment for each office visit for chiropractic treatment or physical therapy when you choose an MPN network provider. You pay an additional \$20 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

You do not need to call MPN before your visit. Your MPN network provider will be responsible for certifying the medical necessity of your care. Charges for all certified services will be paid in full except for your copayments. You do not have to pay more than your copayments to a network provider unless you have agreed in writing in advance to pay for non-covered services.

How to find a network provider

You may contact a provider of chiropractic treatment or physical therapy directly and ask if the provider is in the MPN network. Or, you may call The Empire Plan and choose the Medical Program. MPN network providers are also listed in *The Empire Plan Participating Provider Directory*.

Guaranteed access

What If There Are No MPN Network Providers in Your Area? You are guaranteed that network benefits will be available to you under the Managed Physical Medicine Program. Call The Empire Plan and choose the Medical Program. MPN will make arrangements for you to receive medically necessary chiropractic treatment or physical therapy, and you will pay only your \$20 copayment for each visit. But, you must call first and you must use the provider with whom MPN has arranged your care.

Non-network benefits

If you receive chiropractic treatment or physical therapy from a non-network provider when MPN has not made arrangements for you, you will pay a much higher share of the cost.

Deductible and coinsurance apply

Deductible Applies: For non-network physical medicine office visits, you must meet the Managed Physical Medicine Program annual deductible of \$250. Your spouse/domestic partner must meet the \$250 annual deductible, and all your enrolled children, combined, must meet the \$250 annual deductible. The amount applied toward satisfaction of the deductible will be the amount you actually paid for medically necessary services covered under the Managed Physical Medicine Program or the MPN network allowance for such services, whichever is less. This deductible is separate from other Plan deductibles.

Coinsurance and \$1,500 Annual Maximum Apply: You will be reimbursed up to a maximum of 50 percent of the network allowance for medically necessary services, up to a maximum reimbursement of \$1,500 per covered person per calendar year.

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

If MPN determines that the non-network care you received was not medically necessary, you will not receive any Empire Plan benefits, and you will be responsible for the full cost of care.

Other services

Medically necessary services, such as radiology and diagnostic laboratory tests that are performed by a non-network Managed Physical Medicine provider or provider covered under the Basic Medical Program, are subject to the combined annual deductible and Basic Medical coinsurance maximum.

Questions

Call The Empire Plan and choose the Medical Program, then select the Managed Physical Medicine Program from the automated telephone system menu if you have questions about your coverage for chiropractic treatment or physical therapy.

Appeals: 180-day deadline

In order to appeal MPN's determination, contact the Medical/Surgical Program (see *Contact Information*, page 128). For information on the Medical/Surgical Program claims appeal, see *Appeals*, page 78.

Infertility Benefits

For the purposes of this benefit, infertility is defined as a condition of an individual who is unable to achieve a pregnancy because the individual and/or partner has been diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but has been unable to carry a fetus to full term.

Infertility benefits, including Qualified Procedures, are subject to the same copayments, deductibles, coinsurance maximums and percentages payable as benefits for other medical conditions under the Participating Provider and Basic Medical Programs. Qualified Procedures are subject to a \$50,000 lifetime maximum.

By using participating providers, you minimize your out-of-pocket costs. Benefits for Qualified Procedures are not payable if they are not preauthorized by the Medical/Surgical Program administrator.

What is covered

Covered services and supplies include, but are not limited to, patient education/program orientation, diagnostic testing, ovulation induction/hormonal therapy, artificial/intra-uterine insemination and surgery to enhance reproductive capability.

The Medical/Surgical Program administrator will not exclude coverage for medically necessary care for the diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.



Call The Empire Plan and choose the Medical Program for prior authorization for Qualified Procedures.

Certain procedures, called Qualified Procedures, are covered under The Empire Plan only **if you call the Medical/Surgical Program administrator in advance and receive prior authorization.** Qualified Procedures are specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility. If the Medical/Surgical Program administrator authorizes benefits, the following Qualified Procedures are covered:

- Assisted reproductive technology (ART) procedures including:
 - In vitro fertilization and embryo placement
 - Gamete intra-fallopian transfer (GIFT)
 - Zygote intra-fallopian transfer (ZIFT)
 - Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
 - Assisted hatching
 - Microsurgical sperm aspiration and extraction procedures, including:
 - Microsurgical epididymal sperm aspiration (MESA)
 - Testicular sperm extraction (TESE)
- Sperm, egg and/or inseminated egg procurement, processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of sperm or embryos).

Maximum lifetime benefit

Benefits paid for Qualified Procedures under The Empire Plan are subject to a lifetime maximum of \$50,000 per covered individual. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses associated with Qualified Procedures.

Center of Excellence for Infertility

Centers of Excellence for Infertility are a select group of participating providers recognized by the Medical/Surgical Program administrator as leaders in reproductive medical technology and infertility procedures and contracted by the Medical/Surgical Program administrator to be Centers of Excellence for Infertility. These centers are available to provide to you the listed covered services and supplies and Qualified Procedures. If the Program administrator preauthorizes infertility treatment at a Center of Excellence for Infertility, benefits are payable in full, subject to the maximum lifetime benefit. No copayments will be applied for services provided at the Center of Excellence. Copayments may apply for certain services required by the Center of Excellence and received outside the center (for example, laboratory or pathology tests).

Infertility: Exclusions and limitations

Charges for the following expenses are not covered or payable:

- Experimental infertility procedures. Infertility procedures performed must be accepted as nonexperimental by the American Society of Reproductive Medicine.
- Fertility drugs prescribed in conjunction with assisted reproductive technology and dispensed by a retail pharmacy are not covered under this benefit. Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under The Empire Plan.
- Medical expenses or other charges related to genetic selection.
- Medical expenses or any other charges in connection with surrogacy.
- Any donor compensation or fees charged in facilitating a pregnancy.
- Any charges for services provided to a donor in facilitating a pregnancy.
- 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.
- Psychological evaluations and counseling. See *Section IV: The Empire Plan Mental Health and Substance Abuse Program Certificate of Insurance* for coverage that may be provided for psychological evaluations and counseling.

Other exclusions and limitations that apply to this benefit are included under *Exclusions in the Medical/Surgical Program General Provisions* section, page 66.

Center of Excellence for Cancer Program

The Center of Excellence for Cancer Program provides paid-in-full coverage for cancer-related expenses received through a nationwide network known as Cancer Resource Services (CRS). If you choose to participate in the Center of Excellence for Cancer Program, you receive enhanced benefits as detailed in this section. The enhanced benefits include travel reimbursement and a paid-in-full benefit for services covered under the Program and performed at one of the CRS Centers of Excellence. You will also have access to health care nurse consultants who will answer your cancer-related questions and help you understand your cancer diagnosis. Participation in the Center of Excellence for Cancer Program is voluntary, but the enhanced benefits under the Program are available only when you have enrolled with CRS and notified your case manager before obtaining services.

Facilities covered under the Center of Excellence for Cancer Program include some of the best cancer centers in the United States. For a current list of Centers of Excellence for Cancer, call The Empire Plan, select the Medical Program and then choose the number for Cancer Resource Services.

What is covered

You receive paid-in-full benefits for the following services:

- Inpatient and outpatient hospital and physician care related to the cancer treatment and provided by one of the CRS-contracted Centers of Excellence.
- Cancer clinical trials and related treatment and services. Such treatment and services must be recommended and provided by a physician in a cancer center. The cancer center must be a participating facility in the CRS network at the time the treatment or service is given.

Enrollment

To receive the paid-in-full benefit and the travel benefit, you must call The Empire Plan. Select the Medical Program and then Cancer Resource Services to enroll in the Program.

Other benefits still available

The Center of Excellence for Cancer Program is voluntary. If you choose not to enroll in the Program, you are still eligible for Empire Plan benefits for your covered cancer treatment. Covered medical/

surgical services may be available under the Participating Provider Program or the Basic Medical Program through the Medical/Surgical Program. Covered hospital services may be available through the Hospital Program. You also will have to comply with the requirements of the Empire Plan Benefits Management Program and will have to pay any applicable deductible, coinsurance and copayments.

Centers of Excellence Travel Allowance

When you enroll in the Center of Excellence for Cancer Program or are preauthorized for infertility benefits, you will not have to make any copayments for services performed at a qualified Center of Excellence. A travel, lodging and meal expenses benefit is available to you for travel within the United States. The travel and meals benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, the benefit will include coverage for up to two travel companions. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. 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, taxi or bus fare; shuttle; parking; and tolls.

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

Medical/Surgical Program General Provisions

Exclusions

Charges for the following services, supplies and/or pharmaceutical products are **not** covered medical expenses:

- A. Services, supplies or pharmaceutical products that you received before you were covered under this Plan.
- B. Services, supplies or pharmaceutical products that are **not medically necessary** as defined under *Meaning of Terms Used*, page 42.
- C. Federal legend drugs and insulin dispensed by a licensed pharmacy.
- D. Eyeglasses or contact lenses or exams to prescribe or fit them, except as described in the list of covered medical expenses outlined in the *Basic Medical Program* section, page 52.
- E. Dental services, supplies and/or pharmaceutical products provided by a dentist will not be covered, except as described in the list of covered medical expenses outlined in the *Participating Provider* and *Basic Medical Program* sections. In addition, extractions, dental caries, periodontics (including, but not limited to, gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered.
- F. Services, supplies or pharmaceutical products for the administration of anesthesia if the charges for surgery are not covered under this Plan.
- G. 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.
- H. Services, supplies or pharmaceutical products deemed experimental, investigational or unproven are not covered under this Plan. However, the Medical/Surgical Program administrator may deem an experimental, investigational or unproven 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, investigational or unproven 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 79. If the external appeal agent approves coverage of an experimental, investigational or unproven treatment that is part of a clinical trial, only the costs of services, 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.
- I. 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.
 - J. Services, supplies or pharmaceutical products received because of an occupational injury or an occupational sickness that entitles you to benefits under a workers' compensation or occupational disease law.
 - K. Services, supplies or pharmaceutical products to the extent they are covered under a mandatory motor vehicle liability law that requires that benefits be provided for personal injury without regard to fault.
 - L. 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.
 - M. 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.
 - N. Services, supplies or pharmaceutical products for which you are not required to pay.
 - O. Services, supplies or pharmaceutical products received as a result of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace, that occurs after December 5, 1957.
 - P. Orthopedic shoes and other supportive devices, and services or pharmaceutical products for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations. 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.
 - Q. 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.

- R. Services, supplies and pharmaceutical products rendered for convalescent care, custodial care, sanitarium-type 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.
- S. 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.
- T. Cosmetic or reconstructive surgery or treatment. Surgery or treatment primarily to change appearance is not covered under this Plan. Refer to *What is covered under the Participating Provider Program*, page 49, and *What is covered under the Basic Medical Program (nonparticipating providers)*, page 53, for limited coverage of reconstructive surgery.
- U. Preparation or copying fees for medical summaries and medical invoices for services and/or pharmaceutical supplies rendered.
- V. Services, supplies or pharmaceutical products rendered in conjunction with weight reduction programs, unless the patient is morbidly obese and treatment is in a physician's office. Dietary food supplements or vitamins are not covered medical expenses.
- W. Expenses for skilled nursing services while you are an inpatient.
- X. Expenses for mental health or substance abuse services, supplies and pharmaceutical products, including alcoholism.
- Y. Services or pharmaceutical products furnished on a referral prohibited by the Public Health Law section governing business practices and health services.
- Z. Services, supplies or pharmaceutical products provided by your father, mother, brother, sister, spouse/domestic partner or children.

Coordination of Benefits (COB)

- A. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the reasonable and customary charge for a service or the scheduled pharmaceutical amount for pharmaceutical products covered under both group plans.
- B. Definitions
 - **Plan** means a plan that provides benefits or services for or by reason of medical or dental care and that is one of the following:
 - A group insurance plan.
 - A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium.
 - A self-insured or noninsured plan.
 - Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization.
 - A group service plan.
 - A group prepayment plan.
 - Any other plan that covers people as a group.
 - A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.

- **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan that reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts that do not.

- C. When coordination of benefits applies and The Empire Plan is secondary to other commercial coverage, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the reasonable and customary charge for the service or the scheduled pharmaceutical amount or pharmaceutical product you receive. The amount payable under The Empire Plan plus the amount payable under the primary plan will sometimes be less than 100 percent of the allowable expense due to annual deductible and coinsurance requirements. If The Empire Plan is secondary to Medicare, the amount payable will be determined as denoted in the *Impact of Medicare on This Plan* section, page 70.
- D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a coordination of benefits or similar provision with the same order of benefit determination as stated in item E. and, under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.
- E. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules that applies:
1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent.
 2. When this Plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are not divorced or separated (for coverage of a dependent of parents who are divorced or separated, see item 3.):
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year but
 - If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time.
 - If the other plan does not have the rule described in the preceding two subparagraphs, but instead has a rule based on gender of the parent and, if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.
 3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child.
 - Then, the plan of the spouse of the parent with custody of the child.
 - Finally, the plan of the parent not having custody of the child.
 - If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.

4. The benefits of a plan that covers a person as an employee or as the dependent of an employee who is neither laid off nor retired are determined before those of a plan that covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule (4.) is ignored.
 5. If none of the rules in 1. through 4. determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.
- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
 - G. Any information about covered expenses and benefits needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.
 - H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
 - I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts considered proper under this provision.
 - J. An additional condition applies under the Participating Provider Program. When either Medicare or a plan other than this Plan pays first, and if, for any reason, the total sum reimbursed by the other plan and this Plan is less than the amount billed the other plan, the participating provider may not charge the balance to you.

When The Empire Plan is secondary to another insurance plan

If a provider receives prior approval to provide services from the plan providing primary coverage, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the plan providing primary coverage has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the *Certificate* language.

Impact of Medicare on This Plan

Definitions

- A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.
- B. **Primary Payor** means the plan that will determine the medical benefits that will be payable to you first.
- C. **Secondary Payor** means a plan that will determine your medical benefits after the primary payor.
- D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.
- E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in the *General Information Book*.
- F. You will be considered **disabled** if you are eligible for Medicare due to your disability.
- G. You will be considered to have **end-stage renal disease** if you have permanent kidney failure.

Coverage

When you are eligible for primary coverage under Medicare, the benefits under this Plan will change.

Please refer to the *General Information Book* for information on when you **must** enroll for Medicare and when Medicare becomes your **primary** coverage. **If you or your dependent is eligible for primary Medicare coverage—even if you or your dependent fails to enroll—your covered medical expenses will be reduced by the amount that could be covered under Medicare, and the Medical/Surgical Program will consider the balance for payment, subject to copayment, deductible and coinsurance.**

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization (HMO) under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances.

After you have exhausted your 365 benefit days under Medicare and the Empire Plan Hospital Program, you may use either your Basic Medical coverage under the Medical/Surgical Program or your Medicare Reserve Days.

- A. **Retired Employees and/or Their Dependents** – If you or your dependents are eligible for primary coverage under Medicare—even if you or they fail to enroll—your covered medical expenses will be reduced by the amount that would have been paid by Medicare, and the Medical/Surgical Program administrator will consider the balance for payment, subject to copayment, deductible and coinsurance.

When Medicare pays primary, covered expenses will be based on Medicare’s limiting charge, as established under federal, or in some cases, state regulations rather than the participating provider scheduled allowances, the reasonable and customary charge or the scheduled pharmaceutical amount as defined in the *Meaning of Terms Used*, pages 41, 44 and 46.

No benefits will be paid for services, supplies or pharmaceutical products provided by a skilled nursing facility.

- 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 provisions apply. Medicare will be the secondary payor. As the primary payor, the Medical/Surgical Program administrator will pay benefits for covered medical expenses under this Plan; as secondary payor, Medicare’s benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

Note for domestic partners: Under Social Security law, Medicare is primary for an active employee’s domestic partner who becomes Medicare eligible at age 65, and if the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

- C. **Disability** – Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.
- D. **End-Stage Renal Disease** – For those eligible for Medicare due to end-stage renal disease, NYSHIP will be the primary coverage for the first 30 months of treatment, then Medicare becomes primary. See *End-stage renal disease* in the *General Information Book*. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

- E. **Veterans' Facilities** – Where services are provided in a U.S. Department of Veterans' Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a nongovernmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan's benefits. The Medicare amount payable is the amount that would be payable to a Medicare-eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a nongovernmental facility.
- F. **If you or your dependents are eligible and enrolled for coverage under Medicare and receive services from a health care provider who has elected to opt out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.**
- G. If Medicare is your primary plan and you live in an area that participates in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program and use equipment or supplies included in the Program (or get the items while visiting one of these areas), you must use a Medicare contract supplier. If you live in these areas (or get these items while visiting them) and don't use a Medicare contract supplier, Medicare will not pay for the item and your Empire Plan benefits will be reduced by the amount Medicare would have paid if you had used a contract provider. In order to maximize your benefits, it is important for you to know if you're in an area that is affected by this Medicare program. For more information, you can contact Medicare (see *Contact Information*, page 131). If you need additional assistance locating a Medicare contract supplier, contact the Home Care Advocacy Program (HCAP).

How, When and Where to Submit Claims

How

- A. If you go to a participating provider, Managed Physical Network (MPN) network provider, HCAP-approved provider or a Basic Medical Discount Program provider, all you have to do is ensure that the provider has accurate and up-to-date personal information (name, address, health insurance identification number and signature) needed to complete the claim form. The provider fills out the form and sends it directly to the Medical/Surgical Program administrator. The claim forms are in each provider's office.
- B. If you use a nonparticipating provider or a provider that is not in the MPN network or is not HCAP approved, you may obtain a claim form from your Health Benefits Administrator or the Medical/Surgical Program administrator (see *Contact Information*, page 128) or on NYSHIP Online (click on Forms and select Medical/Surgical Program, and then the applicable form). Deadlines apply for claim submissions (see *When*, page 73).

Have the doctor or other provider fill in all the information requested on the claim form and sign it. If the form is not filled out by the provider and bills are submitted, they must include all the information requested on the claim form. Missing information will delay processing.

If the Hospital Program administrator paid part of the costs, the Statement of Payment sent to you by the Program administrator must be enclosed with the claim.

If Medicare is primary, a Medicare Summary Notice (or Explanation of Medicare Benefits) **must be submitted with the completed form or detailed bills** for all items to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the Medicare Summary Notice and other documents for your records.

Remember: If Medicare provides primary coverage, your provider must submit bills to Medicare first.

When

- A. If you use a participating provider, MPN network provider, HCAP-approved provider or a Basic Medical Discount Program Provider, your provider will submit a claim to the Medical/Surgical Program administrator.
- B. If you use a nonparticipating provider or a provider that is not in the MPN network or is not HCAP approved, claims must be submitted no later than 120 days after the end of the calendar year in which covered medical expenses were incurred or 120 days after Medicare or another plan processes your claim.

However, you may submit claims later if it was not reasonably possible for you to meet this deadline (for example, due to your illness); you must provide documentation.

Where

Completed claim forms with supporting bills, receipts, and, if applicable, your Medicare Summary Notice or your primary insurance statement should be sent to the address listed in the *Contact Information* section, page 128.

Fraud

Any person who intentionally defrauds an insurance company by filing a claim that contains false or misleading information or conceals information necessary to properly evaluate a claim has committed a crime.

Verification of claim information

The Medical/Surgical Program administrator has the right to request from hospitals, doctors or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

Claim inquiries

When you have a question about your claim, you may call The Empire Plan and choose the Medical Program.

If you do not speak English or are hearing-impaired or speech-impaired, you can receive assistance. Contact The Empire Plan and choose the Medical Program. They can direct you on how to get further help through a language translation line or TTY (Teletypewriter). See the *Contact Information* section, page 128, for TTY information.

Claim determinations

The Medical/Surgical Program claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, the Program's claim determination procedure applies to contractual benefit denials. If you disagree with the Program's claim determination, you may submit a request for a review of a claim not involving a clinical matter (see *Appeals* on page 78).

For a description of the utilization review procedures and appeal process for medical necessity or experimental or investigational determinations, see pages 77 through 80.

Preservice claim determinations

A preservice claim is a request that a service or treatment be approved before it has been received. If the Medical/Surgical Program has all the information necessary to make a determination regarding a preservice claim (e.g., a covered benefit determination), the Program will make a determination and provide notice to you or someone designated on your behalf within 15 days from receipt of the claim. (Examples of preservice claims include Benefits Management Program requests for home health care and durable medical equipment under the Home Care Advocacy Program [see page 57], or

Prospective Procedure Review for MRI, MRA, CT, CAT, PET and nuclear medicine tests. Other examples of preservice requests also include voluntary requests to verify coverage, such as predetermination of benefits requests.)

If the Program needs additional information, it will request the information within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the Program administrator receives the information within 45 days, it will make a determination and provide notice to you in writing within 15 days of receipt of the information. If all necessary information is not received within 45 days, the Program will make a determination within 15 calendar days of the end of the 45-day period.

Urgent Preservice Reviews. With respect to urgent preservice review requests, if the Program has all information necessary to make a determination, it will make a determination and provide notice to you by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If the Program needs additional information, it will request it within 24 hours. You will then have 48 hours to submit the information. The Program will make a determination and provide notice by telephone within 48 hours of the earlier of the receipt of the information or the end of the 48-hour period. Written notice will follow within three calendar days of the decision.

Post-service claim determinations

A post-service claim is a request for a service or treatment that you have already received. If the Program has all information necessary to make a determination regarding a post-service claim, it will make a determination and notify you within 30 calendar days of the receipt of the claim. If the Program administrator needs additional information, it will request it within 30 calendar days. You will then have 45 calendar days to provide the information. The Program will make a determination and provide notice to you in writing within 15 calendar days of the earlier of receipt of the information or the end of the 45-day period.

Denial of claim

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

- Another Empire Plan Program administrator has liability for some portion of the expense for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service or
- Another Empire Plan Program administrator has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written preauthorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the preauthorization and
- You provide to the Medical/Surgical Program administrator proof of payment or preauthorization of benefits from the other Empire Plan Program administrator regarding the availability of Empire Plan benefits to you for that medical procedure or service.

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

Right to Convert to an Individual Policy

Enrollees and/or covered dependents who lose eligibility for coverage for any of the following reasons may convert to an individual policy (direct-pay contract):

- Termination of employment (including resignation).
- Loss of eligibility for coverage as an employee or dependent.

- Death of the employee (when the dependent is not eligible as outlined in the *Dependent Survivor Coverage* section of the *General Information Book*).
- COBRA continuation eligibility ends.

An individual policy (direct-pay conversion contract) is not available to enrollees and/or covered dependents who:

- Voluntarily cancel their coverage,
- Had coverage canceled for failure to pay the NYSHIP premium,
- Have existing coverage that would duplicate the conversion coverage or
- Are enrolled in Medicare because of age.

If your coverage under this Plan ends for any cause stated above, the proper form with which to apply for conversion will be sent to you.

When applying for a conversion policy, proof that you are insurable is not required by the Medical/Surgical Program administrator.

Deadlines apply

Your application for conversion to an individual policy and the first premium must be submitted to the Program administrator within 60 days from the date your coverage ends.

If you are under age 65 and eligible for Medicare due to disability, you are eligible for a direct-pay policy unless you have coverage that would duplicate the conversion coverage.

Your dependents may apply for an individual policy under the same conditions if they do so within 45 days after coverage ends because COBRA coverage ends, because of your death or because they no longer qualify as dependents.

Your dependents should request the proper conversion form by writing to the Medical/Surgical Program administrator (see *Contact Information*, page 128).

Please refer to the *General Information Book* for details on how you may continue coverage under COBRA after termination.

Miscellaneous Provisions

Confined on effective date of coverage

If you become covered under this Plan and, on that date, are confined in a hospital or similar facility for care or treatment or are confined at home under the care of a doctor for a sickness, injury or pregnancy, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

Benefits after termination of coverage

If you are totally disabled on the date coverage ends on your account, the Medical/Surgical Program administrator will pay benefits for covered medical expenses to treat the injury, sickness or pregnancy that caused the total disability, on the same basis as if coverage had continued without change, until the date you are no longer totally disabled or for up to 12 months from the date your coverage ended, whichever is earlier. This does not apply if the services are covered under another group health plan or Medicare.

Total Disability and **Totally Disabled** mean that because of a sickness or injury you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

Call The Empire Plan and choose the Medical Program if you need more information about benefits after termination of coverage.

Confined on date of change of options

Option means your choice of either The Empire Plan or a Health Maintenance Organization (HMO) under the New York State Health Insurance Program.

If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or similar facility or confined at home under the care of a doctor:

- A. And the transfer is out of The Empire Plan, and you are confined on the day coverage ends, benefits are payable as set forth under *Benefits after termination of coverage*, page 75.
- B. And the transfer is into The Empire Plan, benefits are payable to the extent they exceed or are not paid through your former HMO.

Termination of coverage

- A. Coverage will end when you are no longer eligible to participate in this Plan. Refer to the *General Information Book*.
- B. If this Plan ends, your coverage will end.
- C. Coverage on account of a dependent will end on the date that dependent ceases to be a dependent as defined in the *General Information Book*.
- D. If a payment required by the State of New York to the cost of coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim incurred before your coverage ends, for any reason, will not be affected (see also, *Benefits after termination of coverage*, page 75).

Recovery of overpayments and subrogation

Recovery of overpayments

On occasion, a payment will be made to you when you are not covered, for a service that is not covered, or in an amount that is more than proper. When this happens, the problem will be explained to you and you must return the amount of the overpayment within 60 days after receiving notification.

Right to offset

If the Medical/Surgical Program makes a claim payment to you or on your behalf in error or you owe the Program money, you must repay the amount owed. Except as otherwise required by law, if the Medical/Surgical Program owes you a payment for other claims received, the Program has the right to subtract any amount owed by you from any payment owed to you.

Subrogation and reimbursement

These paragraphs apply when another party (including another insurer) is, or may be found to be, responsible for your injury, illness or other condition and the Program has provided benefits related to that injury, illness or other condition. As permitted by applicable state law (unless preempted by federal law), the Medical/Surgical Program may be subrogated to all rights of recovery against such party (including your own insurance carrier) for the benefits provided to you under this *Certificate*. Subrogation means that the Program has the right, independently of you, to proceed directly against the other party to recover the benefits the Program provided.

Subject to applicable state law (unless preempted by federal law), the Program may have the right to reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness or condition for which the Medical/Surgical Program provided benefits. Under Section 5-335 of the New York General Obligations Law, the Program's right of recovery does not apply when a settlement is reached between a plaintiff and a defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that you did not take

any action against the Program's rights or violate any contract between you and the Program. The law presumes that the settlement between you and the responsible party does not include compensation for the cost of health care services for which the Medical/Surgical Program provided benefits.

The Medical/Surgical Program requests that you notify them within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or to obtain compensation due to an injury, illness or condition sustained by you for which the Medical/Surgical Program provided benefits. You must provide all information requested by the Program or the Program's representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Program reasonably requests.

Time limits on starting lawsuits

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

Inquiries

If you have any questions regarding your claim or the availability of benefits under this Plan, you should call the Medical Program.

Utilization Review Guidelines

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

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

Concurrent reviews

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

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

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

Retrospective reviews

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

Notice of adverse determination

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

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

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

Appeals

You or another person acting on your behalf may submit an appeal. If a post-service claim (a claim for benefits payment after medical care has been received) or a preservice request for benefits (including a request for benefits that requires notification, precertification or benefit confirmation prior to receiving medical care) is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal by writing to or calling the Medical/Surgical Program administrator (see *Contact Information*, page 128).

Appeal process

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

Level 1 appeals

A request for review must be directed to the Medical/Surgical Program administrator within 180 days after the claim payment date or the date of the notification of denial of benefits. When requesting a

review, you should state the reason you believe the claim determination or precertification improperly reduced or denied your benefits. Also, submit any data or comments to support the appeal of the original determination as well as any data or information requested by the Program administrator. A written acknowledgment of your appeal will be sent to you within 15 days after it is received.

For a first-level appeal of a post-service claim, the appeal will be reviewed and within 30 days of your request, the Program administrator will provide you with a written decision.

For a first-level appeal of a preservice request for benefits, the appeal will be reviewed and within 15 days of your request, the Program administrator will provide you with a written decision.

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

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

Level 2 appeals

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

For a second-level appeal of a post-service claim, the appeal will be reviewed and within 30 days of your request, the Program administrator will provide you with a written decision.

For a second-level appeal of a preservice request for benefits, the appeal will be reviewed and within 15 days of your request, the Program administrator will provide you with a written decision.

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

Appeals involving urgent situations

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

If you are unable to resolve a problem with an Empire Plan Program administrator, you may contact the Consumer Assistance Unit of the New York State Department of Financial Services (see *Contact Information*, page 131).

External appeals

Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Medical/Surgical Program administrator has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal for review of that decision by an external appeal agent, an independent entity certified by the New York State Department of Financial Services to conduct such appeals.

Your right to an immediate external appeal

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

Your right to appeal a determination that a service is not medically necessary

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

- 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 previously 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 must both agree in writing to waive any internal appeal.

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

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

- The service must otherwise be a covered service under the Policy.
- You must have received a final adverse determination through the internal appeal process described previously and if any new or additional information regarding the service or procedure was presented for consideration, the Medical/Surgical Program administrator must have upheld the denial or you must both agree in writing to waive any internal appeal.

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

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

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation. Your attending physician should contact the New York State Department of Financial Services to obtain current information about what documents will be considered acceptable).
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

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

Your right to appeal that a service should be covered because it is considered a rare disease

A rare disease is defined as a condition:

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

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

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

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

The external appeal process

If, through the internal appeal process described previously, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four months from receipt of such notice to file a written request for an external appeal. If you and the Medical/Surgical Program administrator have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. The Program administrator will provide an external appeal application with the final adverse determination issued through the Medical/Surgical Program's internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services (see *Contact Information*, page 131). Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Medical/Surgical Program administrator based its denial, the external appeal agent will share this information with the Program administrator in order for the Program administrator to exercise its right to reconsider its decision. If the Program administrator chooses to exercise this right, the Program administrator will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), the Program administrator does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or the Program administrator. If the external appeal agent requests additional information, it will have five additional business days to make a decision. The external appeal agent must then notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Program administrator by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Program administrator's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Program administrator will provide coverage subject to the other terms and conditions of the Policy.

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

The external appeal agent's decision is binding on both parties. The external appeal agent's decision is admissible in any court proceeding.

You will be charged a fee of \$25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. The fee may also be waived if it is determined that paying it would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an external appeal

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

Four-month external appeal deadline

Under New York State law, your completed request for external appeal must be received by the Department of Financial Services within four months (with an additional eight days allowed for mailing) of the date of the final notice of adverse determination of the first-level appeal or the date upon which you receive a written waiver of any internal appeal. The Medical/Surgical Program administrator has no authority to grant an extension of this deadline.

Section IV: The Empire Plan Mental Health and Substance Abuse Program Certificate of Insurance

Program Overview

The Empire Plan Mental Health and Substance Abuse (MHSA) Program provides comprehensive coverage for mental health and substance abuse care, including alcoholism. ValueOptions is the administrator of the Program.

Note: Effective January 1, 2016, ValueOptions rebranded and changed its name to Beacon Health Options, Inc.

The Empire Plan MHSA Program has two levels of benefits for covered services: network coverage and non-network coverage. Review the benefits and exclusions in this *Certificate* before you obtain services. Please refer to the *Schedule of Benefits for Covered Services*, page 93, for a complete description of the two benefit levels. Excluded services and conditions will not be covered under the Program. Please review *Exclusions and Limitations*, page 95, for a complete description.

Coverage

Covered services for medically necessary mental health and substance abuse care, include:

- Emergency assessments at all times.
- Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge.
- Alternatives to inpatient care (such as certified residential treatment facilities and certified halfway houses).
- Outpatient mental health services.
- Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment.
- Substance abuse structured outpatient rehabilitation and aftercare.
- Electroconvulsive therapy.
- Medication management.
- Ambulance services.
- Psychiatric second opinions.
- Applied behavior analysis with a confirmed diagnosis of Autism Spectrum Disorder.

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

If you have questions about the Empire Plan MHSA Program, you or a member of your family or household may call the Program (see *Contact Information*, page 129).

Calling the MHSA Program is the first step in ensuring that you will be eligible to receive the highest level of benefits. The Clinical Referral Line is available 24 hours a day, every day of the year. It is staffed by clinicians who have professional experience in the mental health and substance abuse field. These highly trained and experienced clinicians are available to help you determine the most appropriate course of action.

By making the call before you receive services, and then obtaining care from a provider referred to you by 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 no network provider is available and the Program administrator refers you to a non-network provider.

Meaning of Terms Used

Here are definitions of the key terms used throughout this *Certificate*. In order to understand them fully, read the entire *Certificate* to learn how these terms are used in the context of the coverage provided to you.

- A. **Applied Behavior Analysis (ABA)** means a behavioral approach commonly used with children with Autistic Spectrum Disorders that seeks to reinforce adaptive behaviors and reduce maladaptive behaviors. ABA includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.
- B. **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial hospitalization, intensive outpatient program, day treatment, 23-hour extended bed and 72-hour crisis bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by the MHSA Program administrator.

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.

- C. **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.
- D. **Certification or Certified** means a determination by the Program administrator that mental health care, substance abuse care or proposed care is a medically necessary, covered service in accordance with the terms of this *Certificate*.
- E. **Clinical Referral Line** means the clinical resource and referral service that you may call prior to receiving any covered services to obtain network referrals or benefit information. You may call 24 hours a day, every day of the year. Call The Empire Plan and choose the Mental Health and Substance Abuse Program.
- F. **Coinsurance** means, for approved facility services, the difference between the billed charge and the percentage covered, and, for non-network practitioner services, the difference between the reasonable and customary charge and the percentage covered. The Plan's coinsurance maximum is shared between the Basic Medical, Hospital and MHSA Programs. **Note:** Copayments paid to a network practitioner count toward meeting your plan coinsurance maximum.
- G. **Combined Annual Coinsurance Maximum** means the amount the enrollee, the enrolled spouse/ domestic partner and all dependent children combined must pay in total, each calendar year, for coinsurance amounts incurred under the Basic Medical, Hospital and MHSA Programs. Copayments for participating provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum. After the combined annual coinsurance maximum is reached, benefits are paid at 100 percent of reasonable and customary charges for non-network covered services.
- H. **Combined Annual Deductible** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each calendar year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program expenses and/or non-network MHSA Program expenses before benefits will be paid under these components of the Plan.

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

- The amount you actually paid for a medically necessary service under the non-network portion of the Program.
- For practitioner services, the reasonable and customary charge.
- For approved facility services, the billed amount for such service.

- I. **Concurrent Review** means the MHSA Program administrator's utilization review and medical management program under which it reviews the medical necessity of mental health care and substance abuse services. The Program administrator's review is conducted by a team of licensed psychiatric nurses, licensed social workers, board-certified or board-eligible psychiatrists and clinical psychologists, to determine whether proposed services are medically necessary for your diagnosed condition(s). This Program includes combined outpatient and inpatient review as described in this *Certificate*.
- J. **Copayment** means the amount you are required to pay for covered services you obtain from a network provider for outpatient services under the MHSA Program. Please refer to *Schedule of Benefits for Covered Services*, page 93, for the exact amount of copayment. Copayment applies only to network covered services and non-network emergency room covered services. **Note:** Copayments paid to a network practitioner count toward meeting your plan coinsurance maximum.
- K. **Course of Treatment** means the period of time, as determined by the MHSA Program administrator, required to provide mental health and substance abuse care to you for the resolution or stabilization of specific symptoms or a particular disorder. A course of treatment may involve multiple providers.
- L. **Covered Expenses** means:
- Under the network portion of the Program, the network allowance for any medically necessary covered services provided to you by a network provider.
 - Under the non-network portion of the Program, the reasonable and customary charge by a non-network practitioner. These services must be medically necessary as defined in this section. No more than the reasonable and customary charge will be considered by the Program for medically necessary covered services. More detail on covered expenses is provided in the section *Schedule of Benefits for Covered Services*, page 93.
- A covered expense is incurred on the date the service is received by you.
- Charges for services performed by a person or facility not listed in the definition of practitioner or approved facility are **not** covered expenses under the Program. A more detailed description of covered expenses and exclusions is provided on the following pages.
- M. **Covered Services** means medically necessary mental health and substance abuse care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.
- N. **Crisis Intervention Visits** means visits for stabilization of an acute emotional disturbance that requires immediate attention to a patient in high distress.
- O. **Emergency Care** is care received for an emergency condition. An emergency condition is:
- A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:
 - Placing the health of the person afflicted with such condition in serious jeopardy, or, with respect to a pregnant woman, the health of the woman and the unborn child in serious jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy,

- Serious impairment to such person's bodily functions,
 - Serious dysfunction of any bodily organ or part of such person or
 - Serious disfigurement of such person.
- A condition described in clause (i), (ii) or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

P. **Inpatient Services** means those services rendered in an approved facility to a patient who has been admitted for an overnight stay and is charged for room and board.

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

R. **Medically Necessary** means a service that the MHSA Program administrator has certified to be:

- Medically required,
- Having a strong likelihood of improving your condition and
- Provided at the lowest appropriate level of care for your specific diagnosed condition in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by the Program administrator.

Although a practitioner may recommend that a covered person receive a service or be confined to an approved facility, that recommendation does not mean:

- That such service or confinement will be deemed to be medically necessary or
- That benefits will be paid under this Program for such service or confinement.

S. **Mental Health Care** means medically necessary care rendered by a covered practitioner or approved facility that is, in the opinion of the MHSA Program administrator, directed predominately at treatable behavioral manifestations of a condition that the Program administrator determines:

- Is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder,
- Substantially or materially impairs a person's ability to function in one or more major life activities and
- Has been classified as a mental disorder in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

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

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

V. **Network Facility** means an approved facility that has entered into a network provider agreement as an independent contractor with the MHSA 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. A non-network facility can be considered a network facility on a case-by-case basis when approved by the Program administrator.

- W. **Network Practitioner** means a practitioner who has entered into an agreement with the MHSA 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 person had a network provider agreement in effect on the date that you obtained services. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by the Program administrator.
- X. **Network Provider** means either a network practitioner or a network facility.
- Y. **Non-Network Coverage** means the level of reimbursement paid by the Program when you receive medically necessary covered services from a non-network provider and you comply with the Program requirements outlined in this *Certificate*.
- Z. **Non-Network Facility** means an approved facility that has not entered into an agreement with the MHSA Program administrator as an independent contractor to provide covered services to you.
- AA. **Non-Network Practitioner** means a practitioner who has not entered into an agreement with the MHSA Program administrator as an independent contractor to provide covered services to you. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by the Program administrator.
- AB. **Non-Network Provider** means a practitioner or approved facility that has not entered into an agreement with the MHSA Program administrator to provide covered services to you.
- AC. **Outpatient Services** means those services rendered in a practitioner's office or in the department of an approved facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.
- AD. **Partial Hospitalization** means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for 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. An approved facility has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program.
- AE. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who renders medical necessity decisions.
- AF. **Practitioner** means:
- A psychiatrist.
 - A psychologist.
 - A licensed clinical social worker in New York State with the "R" privilege. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body.
 - 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. **Benefits for these services are available under network coverage only.**

- 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.

AG. **Program** means the Empire Plan Mental Health and Substance Abuse Program.

AH. **Program Administrator** means the company selected/contracted by the State of New York to administer the Empire Plan MHSA Program. The MHSA Program administrator is ValueOptions. The MHSA Program administrator is responsible for processing claims at the level of benefits determined by The Empire Plan and for performing all other administrative functions under the Empire Plan MHSA Program.

AI. **Provider** means a practitioner or facility that supplies you with covered services under the MHSA Program. The fact that a practitioner or approved facility claims to supply you with mental health or substance abuse services has no bearing on whether that practitioner or approved facility is a provider covered under the Program.

A service or supply that can lawfully be provided only by a licensed practitioner or approved facility will be covered by this Program only if such practitioner or approved facility is in fact properly licensed and is permitted, under the terms of that license, to do so at the time you receive a covered service or supply. A person or facility that is not properly licensed cannot be a covered provider under the Program. The records of any agency authorized to license persons or facilities who supply covered services shall be conclusive as to whether that person or facility was properly licensed at the time you received any service or supply.

AJ. **Reasonable and Customary** means the lowest of:

- The actual charge for services.
- The usual charge for services by the practitioner.
- The usual charge for services of other practitioners in the same or similar geographic area for the same or similar service.

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

AL. **Structured Outpatient Rehabilitation Program** means a program that provides substance abuse care and is an operational component of an approved facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an approved facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents.

The program must also meet all applicable federal, state and local laws and regulations.

A structured outpatient rehabilitation program is a program in which the patient participates, on an outpatient basis, in prescribed formalized treatment, including an aftercare component of weekly follow up. In addition, structured outpatient rehabilitation programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

AM. **Substance Abuse Care** means medically necessary care provided by an eligible provider for the illness or condition that the MHSA Program administrator has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern,
- Substantially or materially impairs a person's ability to function in one or more major life activities and
- Is a condition that has been classified as a substance abuse disorder in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*, unless such condition is otherwise excluded under this Program.

AN. **Total Disability and Totally Disabled** means that because of a mental health/substance abuse condition, you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

AO. **You/Your** means any Empire Plan enrollee covered by this Program and any dependent member of an enrollee's family who is also covered. Enrollee and dependent are defined in your *General Information Book*. Where this *Certificate* refers to "you" making the call to obtain network coverage, "you/your" can also mean a member of your family or household.

How to Receive Benefits for Mental Health and Substance Abuse Care

The MHSA Program has two levels of benefits: network coverage and non-network coverage.

Network coverage

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

- Network providers have been credentialed by the MHSA Program administrator to ensure they meet high standards of education, training and experience.
- A network provider has agreed to accept the network allowance, plus your copayment, if applicable.
- You will have no claims to file. Network providers collect only a copayment from you.

By using a network provider, you will receive network coverage for medically necessary treatment. The Program's network gives you access to a wide range of providers when you need mental health or substance abuse care. These providers are in your community and many of them have been caring for Empire Plan enrollees and their families for years. For assistance with identifying a network provider who can meet your needs, call the Clinical Referral Line 24 hours a day, any day of the year by calling The Empire Plan and selecting the Mental Health and Substance Abuse Program.

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

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

Non-network coverage

Before you choose a non-network provider, consider the high cost of treatment. Non-network providers can bill you for amounts significantly over the amount reimbursed by the Program administrator. **If you choose or use a non-network provider, it is your responsibility to ensure that the non-network provider obtains required certification of services provided to you.**

For a nonemergency admission to a non-network facility (including intensive outpatient programs, partial hospital programs, halfway houses and group homes), you must call the Empire Plan MHSA Program administrator before admission to have the medical necessity of the admission certified.

Most outpatient services do not need prior certification (see *Schedule of Benefits for Covered Services*, page 93). However, all care is subject to review under the Program's medical necessity guidelines. When using a non-network provider, it is your responsibility to ensure that your provider responds to the MHSA Program administrator's requests for the information necessary to review and certify coverage for the services you receive from that provider.

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

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

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

Emergency services

In an emergency situation, you should go or be taken to the nearest hospital emergency room for treatment. If you are admitted to a facility for emergency care, you should call the MHSA Program within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization for certification.

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

When you receive medically necessary covered services from a non-network provider in a certified emergency, the Program will provide network coverage until you can be transferred to a network facility.

Show your identification card

You may be required to show your Empire Plan Benefit Card every time you request covered services from network providers. Possession and use of an identification card does not entitle you to benefits. Coverage for benefits is subject to verification of eligibility for the date covered services are rendered and all the terms, conditions, limitations and exclusions outlined in this *Certificate*.

Release of medical records

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

What Is Covered Under the MHSA Program

This section describes Program coverage for inpatient and outpatient care.

Inpatient care

Coverage for inpatient care includes the following medically necessary services:

- A. **Hospital Services** for the treatment of mental health and substance abuse are covered. If the MHSA Program administrator determines that inpatient treatment is no longer necessary, the Program administrator will notify you, your doctor and the facility no later than the day before the day on which inpatient benefits cease.

The Program administrator will assist you in making the transition from inpatient care to the appropriate level of treatment with a network provider.

- B. **Residential Treatment Facilities, Halfway Houses and Group Homes.** Covered charges will be payable in full under the network coverage if the admission is certified by the Program administrator.
- C. Mental health or substance abuse treatment in a **Partial Hospitalization Program** (day or night care center) and intensive outpatient programs maintained by an approved facility on its premises, is covered.

- D. **Psychiatric Treatment or Consultation While You Are a Mental Health, Substance Abuse or Medical Inpatient in an Approved Facility.** If you are receiving inpatient mental health/substance abuse treatment from a practitioner who bills separately from the hospital or approved facility, you are covered for medically necessary visits. This benefit will be paid under the inpatient care benefit according to the network status of the treating practitioner.
- If you are admitted to a hospital for a medical condition and the admission interrupts your certified outpatient mental health and substance abuse care, you may continue to receive certified care from your practitioner during your inpatient stay. This benefit will be paid under the inpatient care benefit according to the network status of the treating practitioner.
- E. **Inpatient Psychiatric Consultations on a Medical Unit.** You are covered for medically necessary inpatient mental health visits by a practitioner while you are on the medical unit of a hospital. This benefit will be paid under the inpatient care benefit according to the network status of the treating practitioner.
- F. **Prescription Drugs** are covered when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered under the MHSA Program.

Outpatient care

Coverage for outpatient care includes the following medically necessary services:

- A. **Emergency Care** at a hospital for treatment of mental health/substance abuse disorders, where you are not admitted as an inpatient following that care, is considered an outpatient service.
- B. **Office Visits.** You are covered for office visits for medically necessary mental health and substance abuse disorder care.
- C. **Psychiatric Second Opinion.** You are covered for a second opinion by a practitioner of equal or higher credentials. Example: Only another psychologist or a psychiatrist may give a second opinion on a psychologist's diagnosis.
- D. **Family Sessions.** For each patient's alcoholism, alcohol abuse or substance abuse treatment program, benefits are allowed for covered family sessions. When the covered alcoholic, alcohol abuser or substance abuser is participating in a structured outpatient substance abuse rehabilitation program, up to 20 family sessions (per calendar year) for family members covered under the same Empire Plan enrollment are covered by the Program. If the alcoholic, alcohol abuser or substance abuser is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are covered for up to 20 family sessions (per calendar year), subject to the MHSA Program administrator certification.
- E. **Substance Abuse-Structured Outpatient Rehabilitation Program** benefits are covered.
- F. **Psychological Testing and Evaluations.** These services are covered if the Program administrator certifies that they are medically necessary for the condition(s) indicated. 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.
- G. **Ambulance Services for Mental Health and Substance Abuse Care.** Emergency ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and ambulance transportation is required because of an emergency condition. Nonemergency transportation is covered, when medically necessary, if provided by a licensed ambulance service. The following covered medical expenses for ambulance service apply:
- Local emergency ambulance charges are not subject to deductible or coinsurance.

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

You are not covered under this Program for ambulance service to a facility in which you do not receive mental health and substance abuse care.

- H. **Crisis Intervention Visits.** Under network coverage, crisis intervention visits are payable in full up to the network allowance for up to three visits in a given crisis. After the third visit, the \$20 copayment per visit applies. The MHSA Program administrator may request documentation in order to determine if visits are considered crisis intervention. **Paid-in-full benefits for these services are available under network coverage only.**
- I. **Electroconvulsive Therapy.** Electroconvulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All electroconvulsive therapy must be certified by the Program administrator before the service is received.
- J. **Medication Management.** You are covered for office visits to a psychiatrist or registered network nurse practitioner for the ongoing review and monitoring of medications used to treat mental health or psychiatric conditions.
- K. **Home-Based Counseling.** You are covered for medically necessary home-based counseling provided by network practitioners and following all outpatient procedures as practiced in outpatient office visits. **Benefits for these services are available under network coverage only.**
- L. **Registered Nurse Practitioner.** Services provided by a registered nurse practitioner under the direct supervision of a network psychiatrist are covered under the Plan when medically necessary. Nurse practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. **Benefits for these services are available under network coverage only.**
- M. **Telephone Counseling.** Medically necessary telephone counseling provided by a network practitioner is covered. **Benefits for these services are available under network coverage only.**
- N. **Applied Behavior Analysis (ABA).** Services must be provided by or supervised by a licensed provider who is also a certified behavior analyst. The network provider **must** obtain MHSA certification of this care **before** services begin. If services are being provided by a non-network provider, you **must** have your practitioner call the Program and obtain certification of the care **before** services begin.

The MHSA Program administrator reviews outpatient and inpatient treatment

After the initial certification, the MHSA Program administrator monitors your care throughout your course of treatment to make sure it remains consistent with your medical needs. The concurrent review is based on the following criteria and applies whether you choose a network or non-network provider:

- Medical necessity of treatment to date
- Diagnosis
- Severity of illness
- Proposed level of care
- Alternative treatment approaches

The Program administrator must continue to certify the medical necessity of your care for your Empire Plan mental health and substance abuse benefits to continue.

Certification denial and appeal process: Deadlines apply

Only the MHSA Program administrator peer advisor can deny certification. If certification for any covered service is denied, the Program administrator will notify you and the applicable provider of the denial and provide information on how to request an appeal of such decision by telephone. This information will also be provided to you in writing. You will have 180 days to request an appeal.

When you or your provider requests an appeal involving a clinical matter, a different Program administrator peer advisor will review your case and make a determination. The determination will be made as soon as your provider provides all pertinent information to the Program administrator peer advisor in a telephone review. You and your provider will be advised in writing of the decision.

If the peer advisor's determination is to continue to deny certification, you and your provider will be provided with written information on how to request a second-level appeal of the Program administrator's decision. You have 60 days from the date of your receipt of the written denial notice to request a second-level appeal.

Level 2 clinical appeals are conducted by a panel of two board-certified psychiatrists and a clinical manager from the MHSA Program administrator. Panel members must not have been involved in the previous determinations of the case. A determination will be made within 10 business days of the date the Program administrator received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision. See *Appeals: 180-day deadline*, page 104, for additional information.

If an appeal involves an administrative matter, it will be reviewed by an employee of the Program administrator with problem-solving authority above that of the original reviewer. Administrative appeals are reviewed by the MHSA Program administrator.

Schedule of Benefits for Covered Services

The MHSA Program administrator must certify all covered services as medically necessary. If the Program administrator does not certify your inpatient or outpatient treatment as medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

Network coverage for mental health and substance abuse care

If you follow the requirements for network coverage, you are responsible for paying only the following copayments:

- A. You pay the first \$20 charged for each visit to an approved structured outpatient rehabilitation program for substance abuse.
- B. You pay the first \$20 charged for any other outpatient visit, including home-based and telephone counseling in place of an office visit. However, no copayment is required for:
 - Crisis intervention, up to three visits per crisis (after the third visit, the \$20 copayment per visit applies).
 - Electroconvulsive therapy (the inpatient facility and professional charges), if certified by the MHSA Program administrator.
 - Psychiatric second opinion, if requested and certified by the Program administrator.
 - Ambulance service.
 - Mental health 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 care.
- C. You pay the first \$70 charged for emergency care in a hospital emergency room. You will not have to pay this copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

- D. You pay the first \$20 charged for each visit for approved applied behavior analysis (ABA) therapy for Autism Spectrum Disorder. One copayment per visit will apply for all covered ABA services rendered during that visit.

Note: There is no copayment for inpatient care. Copayments paid to a network provider count toward meeting your Empire Plan combined annual coinsurance maximum but **do not** count toward the combined annual deductible.

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

Non-network coverage for mental health and substance abuse care

You are responsible for obtaining MHSa Program certification for care obtained from a non-network provider.

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

- A. **For Practitioner Services:** After you meet The Empire Plan combined annual deductible, 80 percent of reasonable and customary charges for covered services or actual billed charges, whichever is less. You pay the balance of 20 percent (coinsurance) and any charges above the reasonable and customary amount. The covered percentage becomes 100 percent of the reasonable and customary charge amount once each combined coinsurance amount exceeds the combined coinsurance maximum for the calendar year.
- B. **For Approved Facility Services:** 90 percent of billed charges for covered services. The covered percentage becomes 100 percent of the billed charges for covered services once The Empire Plan combined annual coinsurance maximum is met.

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

Each \$1,000 deductible will be reduced to \$500 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

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

Each \$3,000 coinsurance maximum will be reduced to \$1,500 per calendar year for employees in or equated to salary grade level six or below as of January 1 of that year.

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

Maximums

Mental health and substance abuse coverage is unlimited (no maximum) for medically necessary outpatient and inpatient services, except that outpatient treatment sessions for family members of an alcoholic, alcohol abuser or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

Coverage for applied behavior analysis (ABA) is limited to 680 hours for the 2014 plan year.

Beginning in 2015, there is no annual maximum for ABA services, network and non-network combined.

Exclusions and Limitations

Covered services do not include, and no benefits will be provided for the following:

- A. Expenses incurred prior to your effective date of coverage or after termination of coverage, except under conditions described in the *Miscellaneous Provisions* section, page 101.
- B. Services that are not medically necessary as defined in the section *Meaning of Terms Used*, page 84.
- C. Treatment that is not mental health care or substance abuse care as defined in the section *Meaning of Terms Used*, pages 86 and 89.
- D. Services that are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance or solely pursuant to judicial or administrative proceedings.
- E. Services to treat conditions that are identified in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* as non-disorder conditions that may be a focus of clinical attention (V codes), except for family visits for substance abuse or alcoholism.
- F. Services deemed experimental or investigational. However, the MHSA Program administrator may deem an experimental or investigational service is covered under this Program for treating a life-threatening sickness or condition if it determines 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.
- G. Custodial care (the spectrum of clinical and non-clinical services provided expressly for protection and monitoring in a controlled environment, regardless of setting, that do not seek a cure once the signs and symptoms of the patient have been stabilized, resolved or at baseline level of functioning, or the patient is not responding to treatment or otherwise not improving). Examples include but are not limited to:
 - Respite services.
 - State hospital care that is custodial for children who are wards of the state.
 - Enrollees or eligible dependents who are incarcerated in a state hospital facility.
 - Days awaiting placement.
 - Activities that are social and recreational in nature.
 - Services used solely to prevent runaway/truancy or legal problems.
- H. Prescription drugs, except when medically necessary and when dispensed by an approved facility or residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered.
- I. Inpatient private-duty nursing.
- J. Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient treatment reports and statements of medical necessity.
- K. Charges for services, supplies or treatments that are covered charges under any other portion of The Empire Plan, including, but not limited to, detoxification of newborns and medically complicated detoxification cases.

- L. Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.
- M. Services or supplies you receive for which no charge would have been made in the absence of coverage under the MHSA Program, including services from an employee assistance program.
- N. Services or supplies for which you are not required to pay, including amounts charged by a provider that are waived by way of discount or other agreements made between you and the provider of care.
- O. Any charges for professional services performed by a person who is a member of your immediate family or who is related to you, such as a spouse, parent, child, brother or sister or by an individual or institution not defined by the MHSA Program administrator as a provider.
- P. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance plan under an individual policy issued to you, to the extent that medical expenses are identified in the judgment or settlement.
- Q. Conditions resulting from an act of war (declared or undeclared) or an insurrection that occurs after December 5, 1957.
- R. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the MHSA Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service-connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.
- S. Applied behavior analysis (ABA) services, when provided pursuant to an individualized education plan (IEP) under Article 89 of the education law, or under an individualized family service plan (IFSP) or an individualized services plan. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act is not a covered benefit.

Coordination of Benefits (COB)

- A. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the reasonable and customary charge for a service covered under both group plans.
- B. Definitions
 - **Plan** means a plan that provides benefits or services for or by reason of mental health or substance abuse care and that is one of the following:
 - A group insurance plan.
 - A blanket plan, except for blanket school accident coverage or such coverages issued to a substantially similar group where the policyholder pays the premium.
 - A self-insured or noninsured plan.
 - Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization.
 - A group service plan.
 - A group prepayment plan.

- Any other plan that covers people as a group.
- A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.
- **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan that reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts that do not.

- C. When coordination of benefits applies and The Empire Plan is secondary to other commercial coverage, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the reasonable and customary charge for the service you receive.

The amount payable under The Empire Plan, plus the amount payable under the primary plan will sometimes be less than 100 percent of the allowable expense due to the annual deductible and coinsurance requirements. 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 98.

- D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has coordination of benefits or similar provision with the same order of benefit determination as stated in item E. and, under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.
- E. When more than one plan covers the person making the claim, the order of benefit payments is determined using the first of the following rules that applies:
1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent.
 2. When this plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are not divorced or separated (for coverage of a dependent of parents who are divorced or separated, see item 3.):
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year but
 - If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time.
 - If the other plan does not have the rule described in the preceding two subparagraphs, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.
 3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child.
 - Then, the plan of the spouse of the parent with custody of the child.
 - Finally, the plan of the parent not having custody of the child.

- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such actual knowledge.
4. The benefits of a plan that cover a person as an employee or as the dependent of an employee who is neither laid off nor retired are determined before those of a plan that covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule (4.) is ignored.
 5. If none of the rules in 1. through 4. determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.
- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
 - G. Any information about covered expenses and benefits needed to apply this provision may be given or received without consent of or notice to any person, except as required by Article 25 of the General Business Law.
 - H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
 - I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts considered proper under this provision.
 - J. An additional condition applies under the network provider program. When either Medicare or a plan other than this Plan pays first, and if, for any reason, the total sum reimbursed by the other plan and this Plan is less than the amount billed by the other plan, the network provider may not charge the balance to you.

When The Empire Plan is secondary to another insurance plan

If a provider receives prior approval to provide services from the primary plan administrator, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the primary plan administrator has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the *Certificate* language.

Impact of Medicare on This Plan

Definitions

- A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.
- B. **Primary Payor** means the plan that will determine the mental health and substance abuse benefits that will be payable to you first.
- C. **Secondary Payor** means a plan that will determine your mental health and substance abuse benefits after the primary payor.
- D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.

- E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in your *General Information Book*.
- F. You will be considered **disabled** if you are eligible for Medicare due to your disability.
- G. You will be considered to have **end-stage renal disease** if you have permanent kidney failure.

Coverage

When you are eligible for primary coverage under Medicare, the benefits under this Plan may change.

Please refer to your *General Information Book* for information on when you **must** enroll for Medicare and when Medicare becomes your **primary** coverage. **If you or your dependent is eligible for primary Medicare coverage—even if you or your dependent fails to enroll—your covered mental health and substance abuse expenses will be reduced by the amount available under Medicare, and the MHSA Program administrator will consider the balance for payment, subject to copayment, deductible and coinsurance.**

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization (HMO) under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances.

- A. **Retired Employees and/or Their Dependents** – If you or your dependents are eligible for primary coverage under Medicare—even if you or they fail to enroll—your covered mental health and substance abuse expenses will be reduced by the amount that would have been paid by Medicare, and the MHSA 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.

No benefits will be paid for services or supplies provided by a skilled nursing facility.

- 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 provisions apply. Medicare will be the secondary payor. As the primary payor, The Empire Plan will pay benefits for covered mental health and substance abuse expenses under this Plan; as secondary payor, Medicare's benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

Note to domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

- C. **Disability** – Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must be enrolled in Parts A and B of Medicare when first eligible and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.
- D. **End-Stage Renal Disease** – For those eligible for Medicare due to end-stage renal disease, NYSHIP will be the primary coverage for the first 30 months of treatment, then Medicare becomes primary. See *End-stage renal disease* in your *General Information Book*. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

- E. **Veterans' Facilities** – Where services are provided in a U.S. Department of Veterans' Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a non-governmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan's benefits. The Medicare amount payable is the amount that would be payable to a Medicare-eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a nongovernmental facility.
- F. **If you or your dependents are eligible and enrolled for primary coverage under Medicare and receive services from a health care provider who has elected to opt out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.**

Claims

Claim payment for covered services

Claim payments for covered services you receive under this Program will be made only as follows:

- A. **Network Coverage** – When you receive network coverage, the MHSa Program administrator will make any payment due under this Program directly to the provider, except for the copayment amount that you pay to the provider.
- B. **Non-Network Coverage** – When you receive non-network coverage, any payment due under the Program will be made **ONLY** to you. You are responsible for payment of charges at the time they are billed to you. You must file a claim with the MHSa 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. 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, the Program may pay the non-network covered amount directly to an approved facility in lieu of paying you.
- C. **Assignment Prohibited** – Your right under this Program to receive reimbursement for outpatient covered services when such services are provided under non-network coverage, except inpatient services and partial hospitalization where agreed to by the Program administrator, may not be assigned or otherwise transferred to any other person or entity including, without limitation, any such provider. Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program administrator.

How, when and where to submit claims

How

If you use non-network coverage, you must submit a claim. You may obtain a claim form from your Health Benefits Administrator or by calling The Empire Plan and choosing the Mental Health and Substance Abuse Program. You may also download a claim form from the New York State Department of Civil Service website or from the Empire Plan MHSa Program's enrollee website (see *Contact Information*, page 129).

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 MHSa 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.

- A. If you use network coverage, your provider will submit a claim to the MHSA Program administrator.
- B. If you use non-network coverage, you must meet the combined annual deductible before the claims are paid.

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

Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an Explanation of Medicare Benefits form to the MHSA Program administrator (see *Contact Information*, page 129).

Fraud

Any person who intentionally defrauds an insurance company by filing a claim that contains false or misleading information, or conceals information that is necessary to properly examine a claim, has committed a crime.

Verification of claim information

The MHSA Program administrator has the right to request from approved facilities, practitioners or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

Questions

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call The Empire Plan and choose the Mental Health and Substance Abuse Program.

Miscellaneous Provisions

Confined on effective date of coverage

If you become covered under this Plan and on that date are confined in a hospital or inpatient facility for care or mental health or substance abuse treatment or are confined at home under the care of a practitioner for mental health or substance abuse treatment, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

Benefits after termination of coverage

If you are totally disabled due to a mental health or substance abuse condition on the date coverage ends on your account, the MHSA Program will pay benefits for covered expenses for that total disability on the same basis as if coverage had continued without change, until the date you are no longer totally disabled or for up to 12 months from the date your coverage ends, whichever is earlier. This does not apply if the services are covered under another group health plan or Medicare.

Call the Mental Health and Substance Abuse Program administrator if you need more information about benefits after termination of coverage.

Confined on date of change of options

“Option” means your choice under the New York State Health Insurance Program of either The Empire Plan, which includes the MHSA Program or a Health Maintenance Organization (HMO). See your *General Information Book* for information on Option Transfer.

If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or inpatient facility for mental health/substance abuse care or confined at home under the care of a practitioner for mental health/substance abuse care:

- A. And the transfer is out of The Empire Plan, and you are confined on the day coverage ends, benefits will end on the effective date of option transfer.
- B. And the transfer is into The Empire Plan, benefits under the MHSA Program are payable for covered expenses to the extent they exceed or are not paid through your former HMO.

Termination of coverage

- A. Coverage will end when you are no longer eligible to participate in The Empire Plan. Refer to your *General Information Book*.
- B. If this Program ends, your coverage will end.
- C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your *General Information Book*.
- D. If a payment that is required by the State of New York for coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim that is incurred before your coverage ends will not be affected.

COBRA: Continuation of coverage

Your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, a federal continuation of coverage law for you and your covered dependents, are explained in your *General Information Book*.

Recovery of overpayments

On occasion, a payment will be made to you when you are not covered, for a service that is not covered, or in an amount that is more than proper. When this happens, the problem will be explained to you and you must return the amount of the overpayment within 60 days after receiving notification.

Right to offset

If the MHSA Program makes a claim payment to you or on your behalf in error or you owe the Program money, you must repay the amount owed. Except as otherwise required by law, if the MHSA Program owes you a payment for other claims received, the Program has the right to subtract any amount owed by you from any payment owed to you.

Reimbursement

Subject to applicable state law (unless preempted by federal law), the Program may have the right to reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness or condition for which the MHSA Program provided benefits. Under Section 5-335 of the New York General Obligations Law, the Program’s right of recovery does not apply when a settlement is reached between a plaintiff and a defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that you did not take any action against the Program’s rights or violate any contract between you and the Program. The law presumes that the settlement between you and the responsible party does not include compensation for the cost of health care services for which the MHSA Program provided benefits.

The MHSA Program requests that you notify them within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or to obtain compensation due to an injury, illness or condition sustained by you for which the MHSA Program provided benefits. You must provide all information requested by the Program or the Program's representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Program reasonably requests.

Time limit for starting lawsuits

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

Utilization Review Guidelines

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

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

Concurrent reviews

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

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

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

Retrospective reviews

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

Notice of adverse determination

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

Appeals

Appeals: 180-day deadline

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 180 days after you receive a notice of denial of the certification or claim to the MHSA Program administrator appeals department (see *Contact Information*, page 129).

When requesting a review, please state the reason you believe the certification or claim was improperly denied and submit any data, questions or comments you deem appropriate. Upon request to the Program administrator and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefit. In addition, if any new or additional evidence is relied upon or generated by the Program administrator during the determination of the appeal, it will be provided to you free of charge and sufficiently in advance of the due date of the decision of the appeal.

Please refer to *Certification denial and appeal process: Deadlines apply*, page 93, for information about the appeals process.

If you are unable to resolve a problem with an Empire Plan Program administrator, you may contact the Consumer Assistance Unit of the New York State Department of Financial Services (see *Contact Information*, page 131).

External appeals

Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the MHSA Program administrator has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, including treatment of a rare disease, you or your representative may appeal for review of that decision by an external appeal agent, an independent entity certified by the New York State Department of Financial Services to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary

If you have been denied coverage on the basis that the service is not medically necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit), you may appeal for review by an external appeal agent if you satisfy the following two criteria:

- 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 previously and, if any new or additional information regarding the service or procedures was presented for consideration, the Program administrator must have upheld the denial or you both must agree in writing to waive any internal appeal.

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

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

- The service must otherwise be a covered service under the Policy.
- You must have received a final adverse determination through the internal appeal process described previously and, if any new or additional information regarding the service or procedures was presented for consideration, the MHSA Program administrator must have upheld the denial or you both must agree in writing to waive any internal appeal.

Your attending physician must also certify that you have a condition/disease whereby standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial or rare disease treatment (as defined by law).

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

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation. Your attending physician should contact the New York State Department of Financial Services to obtain current information about what documents will be considered acceptable) or, in the case of a rare disease, a health service or procedure that is likely to benefit you in the treatment of a rare disease.
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

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

The external appeal process

If, through the internal appeal process described previously, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four months from receipt of such notice to file a written request for an external appeal. If you and the MHSA Program administrator have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. The Program administrator will provide an external appeal application with the final adverse determination issued through its internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services (see *Contact Information*, page 131). Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Program administrator based its denial, the external appeal agent will share this information with the Program administrator in order for the Program administrator to exercise its right to reconsider its decision. If the Program administrator chooses to exercise this right, it will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), the Program administrator does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or the Program administrator. If the external appeal agent requests additional information, it will have five additional business days to make a decision. The external appeal agent must then notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Program administrator by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Program administrator's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Program administrator will provide coverage subject to the other terms and conditions of the Policy.

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

The external appeal agent's decision is binding on both parties. The external appeal agent's decision is admissible in any court proceeding.

You will be charged a fee of \$25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee. The fee will be waived if it is determined that paying it would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an external appeal

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

Four-month external appeal deadline

Under New York State law, your completed request for appeal must be filed within four months (with an additional eight days allowed for mailing) of either the date upon which you receive written notification from the MHSA Program administrator that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Program administrator has no authority to grant an extension of this deadline.

Section V: The Empire Plan Prescription Drug Program Certificate of Insurance

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

CVS/caremark administers the Empire Plan Prescription Drug Program (the “Program”). CVS/caremark utilizes the administrative and mail distribution services of CVS/caremark Mail Service Pharmacy.

Meaning of Terms Used

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

- A. **Ancillary Charge** means the amount in addition to the applicable copayment an enrollee will pay when purchasing a brand-name drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the discounted ingredient cost of the dispensed brand-name drug and the discounted ingredient cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug. The ancillary charge does not apply if an appeal of the mandatory generic substitution requirement is approved by the Plan; however, the enrollee must pay the applicable non-preferred brand copayment.
- B. **Appeal** means a request for review of your claim in the event a claim has been denied as not medically necessary or as a result of investigational or experimental use of a covered prescription drug in whole or in part.
- C. **Brand-Name Drug** means a prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition.
- D. **Compound Drug(s)/Medication(s)** or **Compounded Drug(s)/Medication(s)** means a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA-approved covered drug with a valid National Drug Code (NDC) requiring a prescription for dispensing, combined together in a method specified in a prescription issued by a medical professional. The end result of this combination must be a prescription drug for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The prescription must identify the multiple ingredients in the compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA-approved package insert prior to dispensing will not be considered a compound prescription by this Program.
- E. **Controlled Drug** means a drug designated by federal law or New York State law as a Class I, II, III, IV or V substance. A controlled drug includes, but is not limited to, some tranquilizers, stimulants and pain medications.
- F. **Designated Specialty Pharmacy** means a pharmacy that has entered into an agreement with the Prescription Drug Program administrator to provide specific specialty drugs/medications. The Empire Plan’s designated specialty pharmacy is CVS/caremark.

- G. **Doctor** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), who is legally licensed, without limitations, to practice medicine. For benefits provided under this *Certificate*, and for no other purpose, doctor also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.
- H. **Exception** means a request for review of a previous decision made by the Empire Plan Prescription Drug Program that does not involve denial based on medical necessity or as a result of an investigational or experimental use of a covered prescription drug in whole or in part.
- I. **Excluded Drug** is a drug that is excluded from coverage under this Program's benefit plan design. This Program will provide no benefit for an excluded drug and you will be responsible for paying the total retail cost of the drug. See the definition for *Medical Exception Process* below for information on how to appeal an excluded drug.
- J. **First Fill** means an enrollee's initial or very first dispensing of a specialty drug/medication covered under the Empire Plan Specialty Pharmacy Program.
- K. **Flexible Formulary**. In a flexible formulary, brand-name drugs may be assigned to different copayment levels based on value to this Program and clinical judgment. In some cases, drugs may be excluded from coverage if a therapeutic equivalent is covered or available as an over-the-counter drug.
- L. **Generic Drug** means a drug sold under its chemical name or sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term generic drug shall include authorized generics marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through a U.S. Food and Drug Administration (FDA) generic drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs, shall be classified as a generic drug.
- M. **Grace Fill for Specialty Drugs** means that an enrollee is allowed to have the first fill of certain specialty drugs/medications dispensed from a pharmacy other than 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 do not have a grace fill.
- N. **Mail Service Pharmacy** means all facilities that are owned, operated or affiliated with the Prescription Drug Program administrator to fill enrollee prescriptions for all drugs covered by the Program through the mail service pharmacy. The mail service pharmacy utilized by the Program administrator shall dispense drugs per the terms of this *Certificate* and in accordance with the laws, rules and regulations that govern pharmacy practice.
- O. **Medical Exception Process** is a process by which a physician can request a medical necessity review for non-formulary prescription drugs that are excluded from coverage. An appropriate trial of formulary alternatives must be undertaken before a medical exception can be requested.
- P. **Medically Necessary Drug** means any drug that, as determined by the Prescription Drug Program administrator, is:
- Provided for the diagnosis or treatment of a medical condition,
 - Appropriate for the symptoms, diagnosis or treatment of a medical condition,
 - Within the standards of generally accepted health care practice and
 - Not used for cosmetic purposes.

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

- Another Empire Plan Program administrator has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug and has paid benefits in accordance with Empire Plan provisions on your behalf for a medical procedure or service related to the administration of that drug or
- Another Empire Plan Program administrator has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug and has provided to you a written preauthorization of benefits based on their determination of medical necessity, stating that The Empire Plan benefits will be available to you for a medical procedure or service related to the administration of that drug and
- You provide to the Program proof of payment or preauthorization of benefits from the other Empire Plan Program administrator based on their determination of medical necessity regarding the availability of Empire Plan benefits to you for a medical procedure or service related to the administration of that drug.

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

- Q. **Network Pharmacy** means a pharmacy other than a mail service pharmacy or the designated specialty pharmacy that has entered into a contract with the Prescription Drug Program administrator as an independent contractor to dispense drugs per the terms of the contract. It must regularly dispense drugs described in the *What is covered* section, page 113.
- R. **No-Fault Motor Vehicle Plan** means a motor vehicle plan that is required by law. It provides medical or dental care payments that are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.
- S. **Non-Network Pharmacy** means any pharmacy, other than a mail service pharmacy, that has not entered into a contract with the Prescription Drug Program administrator to dispense drugs. The enrollee must file a claim form with the Program administrator in order to receive reimbursement for covered drugs received from a non-network pharmacy.
- T. **Non-Preferred Drug** means a brand-name drug that is not subject to a Level 1 or Level 2 copayment on the Empire Plan Flexible Formulary drug list.
- U. **Pharmacist** means a person who is legally licensed to practice the profession of pharmacy. He or she must regularly practice such profession in a pharmacy.
- V. **Pharmacy** means an establishment that is registered as a pharmacy with the appropriate state licensing agency or is a Veterans' Affairs medical center or hospital pharmacy, and regularly dispenses drugs that require a prescription from a doctor. Drugs described in the section *What is covered*, page 113, must be regularly dispensed from the pharmacy by a pharmacist.
- W. **Preferred Drug** means a brand-name drug that is subject to a Level 1 or Level 2 copayment on the Empire Plan Flexible Formulary drug list.
- X. **Prescription** means the written, oral or electronic request for drugs issued by a provider duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.
- Y. **Prescription Drug Program Administrator** means the company contracted by the State of New York to administer the Empire Plan Prescription Drug Program. The Prescription Drug Program administrator is CVS/caremark. The Program administrator is responsible for processing claims at the level of benefits determined by The Empire Plan and for performing all other administrative functions under the Empire Plan Prescription Drug Program.

- Z. **Program** means the Empire Plan Prescription Drug Program described in this *Certificate*.
- AA. **Specialty Drugs/Medications** mean drugs that treat rare disease states; require special handling, special administration or intensive patient monitoring/testing; biotech drugs developed from human cell proteins and DNA targeted to treat disease at the cellular level; or other drugs used to treat patients with chronic or life-threatening diseases.
- AB. **Therapeutic Category** means categories by which drugs are identified and grouped by the main conditions they treat.
- AC. **Therapeutic Equivalent** means prescription drug products that, when compared, can be expected to produce essentially the same therapeutic outcome and toxicity as determined by the Prescription Drug Program administrator.
- AD. **Vaccination Network Pharmacy** means an Empire Plan network pharmacy other than a mail service pharmacy or the designated specialty pharmacy that has entered into a contract with the Empire Plan Prescription Drug Program administrator to administer covered seasonal and non-seasonal preventive vaccinations when administered by a licensed pharmacist, or, when authorized by applicable law or regulation, a pharmacy intern.
- AE. **Workers' Compensation Law** means a law that requires employees to be covered, at the expense of the employer, for benefits in case they are disabled because of accident or sickness or billed due to a cause connected with their employment.
- AF. **You, Your** or **Yours** refers to you, the eligible enrollee to whom this *Certificate* is issued. It also refers to your eligible enrolled dependents covered under this Program. For information on eligibility, refer to your *General Information Book*.

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

Your Benefits and Responsibilities

Copayments

Copayments for covered drugs are based on the drug, the days' supply and whether the prescription is filled at a network pharmacy, mail service pharmacy or the designated specialty pharmacy. Most Level 1 contraceptive drugs and devices are not subject to copayment.

When you fill your prescription for a covered drug for up to a **30-day supply at a network pharmacy, a mail service pharmacy or the designated specialty pharmacy**, your copayment is:

- **\$5** for most **generic** drugs or Level 1 Drugs
- **\$25** for **preferred** drugs, compound drugs or Level 2 Drugs
- **\$45** for **non-preferred** drugs, certain **generic** drugs or Level 3 Drugs

When you fill your prescription for a **31- to 90-day supply at a network pharmacy**, your copayment is:

- **\$10** for most **generic** drugs or Level 1 Drugs
- **\$50** for **preferred** drugs, compound drugs or Level 2 Drugs
- **\$90** for **non-preferred** drugs, certain **generic** drugs or Level 3 Drugs

When you fill your prescription for a **31- to 90-day supply through a mail service pharmacy or the designated specialty pharmacy**, your copayment is:

- **\$5** for most **generic** drugs or Level 1 Drugs
- **\$50** for **preferred** drugs, compound drugs or Level 2 Drugs
- **\$90** for **non-preferred** drugs, certain **generic** drugs or Level 3 Drugs

Note: Oral chemotherapy drugs for the treatment of cancer do not require a copayment. Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices) do not require a copayment.

Refills are valid for up to one year from the date the prescription is written, subject to applicable state and federal laws.

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

Supply and coverage limits

Certain drugs may be subject to quantity-level limits based on clinical and safety factors related to the dispensing of the drug. Additional clinical quantity-level limits are based on criteria developed by the Prescription Drug Program administrator. The number of days' supply for controlled drugs is in accordance with federal and state mandates.

Erectile dysfunction drugs are limited to a specific quantity-per-day supply: 6 units for a 30-day supply and 7 to 18 units for a 31- to 90-day supply.

Specialty drugs/medications may be dispensed for up to a 90-day supply when clinically appropriate. Certain specialty drugs/medications may only be dispensed for up to a 30-day supply due to clinical/dispensing guidelines.

For certain drugs that have quantity-level limits, additional quantities may be covered through prior authorization. These drugs will be noted with QL/PA on the formulary. Please see *Prior authorization required for certain drugs*, page 112, for information on how to request a prior authorization.

Mandatory generic substitution

When your prescription is written dispense as written (DAW) for a brand-name drug that has a generic equivalent, you pay the non-preferred copayment plus the ancillary charge, not to exceed the full retail cost of the drug. When your prescription is not written DAW, in most cases, the generic equivalent is substituted for the brand-name drug and you pay the generic drug copayment.

The following brand-name drugs are excluded from mandatory generic substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. For these drugs, you pay only the applicable copayment, which, in most cases, will be the non-preferred copayment.

Please refer to the *Miscellaneous Provisions* section, page 122, for information regarding the medical exception process for drugs that are excluded from the Flexible Formulary.

If your doctor believes it is medically necessary for you or your family member to have a brand-name drug (that has a generic equivalent), you may appeal the mandatory generic substitution requirement. To begin the appeal process, your doctor should call The Empire Plan and choose the Prescription Drug Program.

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

If your appeal is granted and you fill your prescription for a brand-name drug at a network pharmacy or through a mail service pharmacy or the designated specialty pharmacy, you pay the non-preferred copayment. If your appeal is denied, you can make a second appeal to the Program administrator.

Empire Plan Flexible Formulary

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

Drugs on the Empire Plan Flexible Formulary are grouped into levels and your copayment is determined by the “Level” that your medication is on.

- Level 1 drugs have the lowest copayment and include most covered generic drugs and certain brand-name drugs.
- Level 2 drugs have the mid-range copayment and include preferred brand-name drugs that have been selected because of their overall health care value.
- Level 3 drugs have the highest copayment and include non-preferred brand-name drugs and certain generic drugs.

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

- When advantageous to the Plan, the brand-for-generic feature allows a brand-name drug to be placed on Level 1, the lowest copayment level, and the new generic equivalent to be placed on Level 3, the highest copayment level, or excluded. These placements are for a limited time, typically six months, and may be revised mid-year when such changes are advantageous to The Empire Plan.
- Certain therapeutic categories of prescription drugs with two or more clinically sound and therapeutically equivalent Level 1 options may not have a brand-name drug in Level 2.
- Access to one or more drugs in select therapeutic categories may be excluded (not covered) if the drug(s) has no clinical advantage over other generic drug(s) and brand-name drug(s) in the same therapeutic category.

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

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

Please refer to the *Exclusions and Limitations* section, page 115, for information about where you can find a list of drugs not covered by the Empire Plan Prescription Drug Program.

New to You prescriptions

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

Prior authorization required for certain drugs

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for certain drugs. If your doctor prescribes one of these drugs, the Prescription Drug Program administrator will request from your doctor the clinical information required to authorize coverage of the drug. Your doctor may contact the Program administrator to begin the authorization process. The Program administrator and/or pharmacy will notify you of the results of the review. The prior authorization requirements apply whether you use your Empire Plan Benefit Card or will be filing a claim for direct reimbursement.

For a current list of drugs that require prior authorization, visit NYSHIP Online at www.cs.ny.gov/employee-benefits and choose your group and plan, if prompted. From the NYSHIP Online homepage, select Using Your Benefits and then click on Drugs that Require Prior Authorization.

Certain drugs that require prior authorization based on age, gender or quantity-limit specifications are not listed. Compound drugs that have a claim cost to the Program that exceeds \$200 will require prior authorization under this Program. This list of drugs is subject to change. For the most current list of drugs requiring prior authorization and to learn how to obtain prior authorization, call The Empire Plan and choose the Empire Plan Prescription Drug Program or visit our website (see *Contact Information*, page 130).

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

An appeal process allows you or your doctor to ask for further review if authorization is not granted. You may call The Empire Plan and choose the Prescription Drug Program for information on how to initiate an appeal.

Specialty Pharmacy Program

Under the Empire Plan Specialty Pharmacy Program, when your physician prescribes a covered specialty drug/medication, you may be directed to the designated specialty pharmacy to obtain benefits under the Program.

The Program requires certain specialty drugs/medications to be dispensed by the designated specialty pharmacy. When initiating therapy with a specialty drug/medication, you may send the prescription directly to the designated specialty pharmacy to start receiving Specialty Pharmacy Program benefits. Otherwise, you are allowed one grace fill for specialty drugs, during which time the Program will cover the first fill of your medication at any network pharmacy with the applicable copayment. (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.)

After your first fill, you are covered for subsequent fills of your specialty drug/medication when dispensed by the designated specialty pharmacy. You will be charged the mail service copayment for covered specialty drugs/medications dispensed by the designated specialty pharmacy.

The Empire Plan Specialty Drug/Medication list is subject to change without notice. To view the most current list, go to the NYS Department of Civil Service website or call the Empire Plan Prescription Drug Program (see *Contact Information*, page 130).

If you pay the full cost of your specialty drug/medication at a pharmacy other than the designated specialty pharmacy, you will be required to file a claim for reimbursement. You will not be reimbursed the total amount you paid for the prescription and you will be responsible for the difference between the amount charged and amount you are reimbursed under this Program. Your out-of-pocket expense may exceed the usual mail service copayment amount.

What is covered

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

- A. FDA-approved drugs that must bear the legend "Rx Only."
- B. State-restricted drugs (drugs or medicines that can be dispensed in accordance with New York State law [or by the laws of the state or jurisdiction in which the prescription is filled] by prescription only).
- C. Compound drug(s)/medication(s).
- D. Injectable insulin.
- E. First fill of a specialty drug/medication filled at a network, 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 that bear the legend “Rx Only;” diaphragms; and contraceptive devices.
- G. Vitamins that are FDA-approved prescription drugs and bear the legend “Rx Only.”
- H. Covered prescription drugs dispensed by on-premises pharmacies to patients in a skilled nursing facility, rest home, sanitarium, extended care facility, convalescent hospital or similar facility. Such on-premises pharmacies are considered non-network pharmacies and require submission of a claim form for reimbursement.
- I. Claims for drugs dispensed outside of the United States that have an available U.S. FDA-approved equivalent.
- J. Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.
- K. Off-label cancer drugs.
- L. Smoking cessation drugs, including over-the-counter drugs for which there is a written order, and prescription drugs prescribed by a physician or other provider.
- M. 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.

* The zero copayment benefit for the herpes zoster vaccine is for individuals age 60 and older. The immunization is covered for individuals ages 55 to 59 at the Level 1 copayment.

Please refer to the following section, *Exclusions and Limitations*, for conditions under which benefits are not available.

Exclusions and Limitations

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

- A. Drugs obtained with no prescription order, including over-the-counter products (except insulin, smoking cessation drugs and over-the-counter preventive drugs or devices provided in accordance with guidelines supported by the Health Resources and Services Administration or with an “A” or “B” rating from the United States Preventive Services Task Force).
- B. Drugs taken or given at the time and place of the prescription order and billed by the doctor.
- C. Drugs provided or required by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay.
- D. Drugs for which there is no charge or legal obligation to pay in the absence of insurance.
- E. Drugs administered to you by the facility while a patient in a licensed hospital. This limit applies only if the hospital in which you are a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals and dispenses such drugs administered to you by the hospital.
- F. Any drug refill that is more than the number approved by the doctor.
- G. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments or other non-medicinal substances), regardless of their intended use.
- H. The administration of any drug or injectable insulin, with the exception of covered preventive vaccines administered at a vaccination network pharmacy.
- I. Any drug refill that is dispensed more than one year after the original date of the prescription order, subject to applicable state and federal laws.
- J. Any drug labeled “Caution: Limited by Federal Law to Investigational Use,” or experimental drugs except for drugs used for the treatment of cancer as specified in Section 3221(k)12 of New York

State Insurance Law as may be amended from time to time. Prescribed drugs approved by the U.S. Food and Drug Administration (FDA) for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or any drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Experimental or investigational drugs shall also be covered when approved by an external appeal agent in accordance with an external appeal. For external appeal provisions, see *Your right to an external appeal*, page 124. If the external appeal agent approves coverage of an experimental or investigational drug that is part of a clinical trial, only the costs of the drug will be covered. Coverage will not be provided for the costs of experimental or investigational drugs or devices, the costs of nonhealth-care services, the costs of managing research or costs not otherwise covered by The Empire Plan for nonexperimental or noninvestigational drugs provided in connection with such clinical trial.

- K. Immunizing agents, with the exception of covered preventive vaccinations administered at a vaccination network pharmacy, biological sera, blood or blood plasma, except immune globulin.
- L. Any drug that a doctor or other health professional is not authorized by his or her license to prescribe.
- M. Drugs for an injury or sickness related to employment for which benefits are provided by any state or federal workers' compensation, employers' liability or occupational disease law or under Medicare or other governmental program, except Medicaid.
- N. Drugs purchased prior to the start of coverage or after coverage ends. However, if the person is totally disabled on the date this insurance ends, see *Benefits after termination of coverage*, page 121.
- O. Any drug prescribed and/or dispensed in violation of state or federal law.
- P. Prescription drug products excluded from the benefit plan design. For a current list of excluded drugs, visit NYSHIP Online at www.cs.ny.gov/employee-benefits and choose your group and plan, if prompted. From the NYSHIP Online homepage, select Using Your Benefits and then click on the Excluded Drug List.
- Q. New prescription drug products that are in the same therapeutic category as existing drugs excluded under the Empire Plan Flexible Formulary or that are in the same therapeutic category as drugs excluded from benefit coverage under this Plan. Please refer to the New York State Department of Civil Service website or call the Empire Plan Prescription Drug Program (see *Contact Information*, page 130) for current information regarding exclusions of newly launched prescription drugs.
- R. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include but are not limited to:
 - Anorexiant, except for morbid obesity.
 - Products used to promote hair growth.
 - Products (for example, Retinoic Acid) used for prevention of skin wrinkling.
- S. Coverage for drugs where the amount dispensed exceeds the supply limit.
- T. Coverage for drugs as a replacement for a previously dispensed drug.
- U. Products for which the primary use is nutrition.
- V. Any non-medically necessary drugs.
- W. Claims for foreign drugs for which there is no available U.S. equivalent approved by the FDA.

Important: See your *General Information Book* for other conditions that may affect this coverage. Refer to *Home Care Advocacy Program (HCAP)* in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, page 57, for coverage for prescription drugs billed by a home care agency.

How to Use Your Empire Plan Prescription Drug Program

When your doctor prescribes a medically necessary drug covered under The Empire Plan, you can fill the prescription for a supply of up to 90 days and refills for up to one year, subject to applicable state and federal laws, in one of four ways: at a network pharmacy, at a non-network pharmacy, through a mail service pharmacy or through the designated specialty pharmacy.

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

Network pharmacies and vaccination network pharmacies

You can use your Empire Plan Benefit Card for covered prescription drugs at Empire Plan network pharmacies. All Empire Plan network pharmacies can fill prescriptions for supplies of up to 90 days. Refills of covered drugs are provided for up to a year from the date the prescription is written, subject to applicable state and federal laws. Only one copayment applies for up to a 90-day supply.

You may also use your Empire Plan Benefit Card for covered preventive vaccinations (see item M. in *What is covered*, page 114) administered at Empire Plan vaccination network pharmacies. Not all Empire Plan vaccination network pharmacies stock all of the covered preventive vaccines, and some may also decline to provide vaccinations to minors based on state law or clinical considerations. It is advised that you call the pharmacy to confirm participation and availability of specific vaccines. Many retail pharmacies in New York State participate in this Program. Many out-of-state pharmacies participate as well.

Be sure your pharmacist knows that you and your family have Empire Plan Prescription Drug Program coverage when you submit your prescriptions or receive a vaccination.

To find a network pharmacy or vaccination network pharmacy, check with your pharmacist, call The Empire Plan and choose the Empire Plan Prescription Drug Program, or visit the website (see *Contact Information*, page 130).

Non-network pharmacies

You can use a non-network pharmacy or pay the full amount for your prescription at a network pharmacy (instead of using your Empire Plan Benefit Card) and fill out a claim for reimbursement.

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

Out-of-Pocket Expenses: When you use a non-network pharmacy or pay the full amount for your prescription at a network pharmacy, you are responsible for the difference between the amount charged and the amount you are reimbursed under this Program.

For claim forms, call The Empire Plan and choose the Empire Plan Prescription Drug Program or download one from the website (see *Contact Information*, page 130).

Mail the completed form with your bills or receipts to the Empire Plan Prescription Drug Program (see *Contact Information*, page 130).

Several factors affect the amount of your reimbursement:

- If your prescription was filled with a generic drug, a brand-name drug with no generic equivalent or insulin, you will be reimbursed up to the amount this Program would reimburse a network pharmacy for that prescription as calculated using the Program's standard reimbursement rate for network pharmacies, less the applicable copayment.
- If your prescription was filled with a brand-name drug with a generic equivalent (other than drugs excluded from mandatory generic substitution), you will be reimbursed up to the amount this Program would reimburse a network pharmacy for filling the prescription with that drug's generic equivalent as calculated using the Program's standard reimbursement rates for network pharmacies, less the applicable copayment (in most cases, that will be the non-preferred copayment).

- Any covered preventive vaccination administered in a pharmacy other than an Empire Plan vaccination network pharmacy will be covered as a non-network claim under the Empire Plan Medical/Surgical Program.

Please refer to *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance* for non-network claim reimbursement instructions.

Deadline for filing claims

Claims must be submitted within 120 days after the end of the calendar year in which the prescription drugs were purchased, or 120 days after another plan processes your claim, whichever is later, unless it was not reasonably possible for you to meet this deadline (for example, due to your illness).

Mail service pharmacy or the designated specialty pharmacy

All drugs covered by the Program can be ordered through a mail service pharmacy or the designated specialty pharmacy.

You can order and receive up to a 90-day supply of your prescriptions, shipped by first-class mail or private carrier. You can pay your copayment(s) and other costs by credit card, check or money order. To request mail service envelopes, refills or to speak to a pharmacist about your mail service prescription, call The Empire Plan and choose the Empire Plan Prescription Drug Program, 24 hours a day, seven days a week (see *Contact Information*, page 130). The mail service pharmacy or the designated specialty pharmacy address is also listed here.

Using the Empire Plan Flexible Formulary drug list

One way you can help control the rapidly increasing cost of prescription drugs is to encourage your doctor(s) to prescribe and pharmacist to dispense covered generic and preferred drugs listed on the Empire Plan Flexible Formulary drug list. (The Empire Plan Flexible Formulary drug list is available on NYSHIP Online; see *Contact Information*, page 128.) This is not a complete list of all prescription drugs on the Flexible Formulary or covered under The Empire Plan. This list and excluded medications are subject to change. New prescription drugs may be subject to exclusion when they become available in the market.

This list provides the most commonly prescribed generic and brand-name drugs included on the Empire Plan Flexible Formulary drug list. These drugs are safe and effective alternatives to higher-cost drugs. Using prescription drugs that appear on this list will save you money. Using generics will save you even more.

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

Remember, if your doctor prescribes a prescription drug that is excluded from coverage under The Empire Plan benefit plan design, you will pay the full retail cost for your prescription. See *Medical exception process for drugs excluded from the Flexible Formulary*, page 122.

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

Coverage for preventive vaccines administered in a vaccination network pharmacy

Empire Plan-primary enrollees and dependents may obtain seasonal and non-seasonal preventive vaccines administered at a vaccination network pharmacy with no copayment in accordance with the Patient Protection and Affordable Care Act (PPACA) mandates. The following preventive vaccines are covered: influenza – flu, pneumococcal – pneumonia, meningococcal – meningitis and herpes zoster – shingles.

Notes:

- New York State restricts pharmacists from administering vaccines to anyone younger than 18. Regulations regarding age limits may differ by state.
- New York State requires a prescription for the herpes zoster vaccine.
- The no-copayment benefit for the herpes zoster vaccine is applicable to enrollees and dependents age 60 or older (as per PPACA recommendations). The herpes zoster vaccine is also available to enrollees and dependents between the ages of 55 and 59, subject to the Level 1, 30-day supply copayment.
- Medicare-primary enrollees and dependents already have coverage for these vaccines in a pharmacy setting under Medicare Parts B and D.

Contact the Empire Plan Prescription Drug Program

For questions about your Empire Plan Prescription Drug Program, call The Empire Plan and choose the Empire Plan Prescription Drug Program.

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

- Verify your eligibility.
- Find out if your claims have been paid.
- Locate an Empire Plan network pharmacy.
- Order refills from a mail service pharmacy or the designated specialty pharmacy or check order status.
- Talk to a customer service representative.
- Request prior authorization or a generic appeal.
- Talk to a pharmacist.

Visit NYSHIP Online. Then choose Find a Provider and scroll to the Prescription Drug Program links if you need to:

- Locate an Empire Plan network pharmacy.
- Order refills online from the mail order pharmacy or check order status.
- Order refills online from the designated specialty pharmacy and check order status.
- Download a mail service pharmacy order form.
- View the list of drugs subject to prior authorization.
- View the Flexible Formulary drug list.

Coordination of Benefits (COB)

- A. **Coordination of Benefits** means that the benefits provided for you under the Empire Plan Prescription Drug Program are coordinated with the benefits provided for you under another group plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the total allowable charge for a service covered under both group plans.

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

B. Definitions

- **Plan** means a plan that provides benefits or services for or by reason of medical or dental care and that is one of the following:
 - A group insurance plan.
 - A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium.
 - A self-insured or noninsured plan.
 - Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization.
 - A group service plan.
 - A group prepayment plan.
 - Any other plan that covers people as a group.
 - A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.
- **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan. Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan that reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts that do not.

C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the total allowable charge for the service you receive.

D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a coordination of benefits or similar provision with the same order of benefit determination as stated in item E., and under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.

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

1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent.
2. When this Plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are not divorced or separated. (For coverage of a dependent of parents who are divorced or separated, see item 3.)
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year but
 - If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time.
 - If the other plan does not have the rule described in the preceding two subparagraphs, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.

3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child.
 - Then, the plan of the spouse of the parent with custody of the child.
 - Finally, the plan of the parent not having custody of the child.
 - If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.
 4. The benefits of a plan that covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan that covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule and if as a result the plans do not agree on the order of benefits, this rule (4.) is ignored.
 5. If none of the rules in 1. through 4. determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.
- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
 - G. Any information about covered expenses and benefits that is needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.
 - H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
 - I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts that are considered proper under this provision.

Medicare Prescription Drug Coverage

NYSHIP replaced the Empire Plan Prescription Drug Program coverage for Medicare-primary enrollees and Medicare-primary dependents with Empire Plan Medicare Rx (PDP), a Medicare Part D prescription drug program with expanded coverage designed especially for NYSHIP.

This prescription drug coverage is administered by CVS/caremark. Eligible individuals are enrolled automatically in Empire Plan Medicare Rx. Prior to enrollment, affected enrollees and dependents will receive important plan benefit information from the New York State Department of Civil Service and the Prescription Drug Program administrator. No action is required by you to enroll in Empire Plan Medicare Rx and keep your Empire Plan coverage.

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

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

Miscellaneous Provisions

Termination of coverage

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

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

- B. If this Program ends, your Program coverage will end.

- C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your *General Information Book*.

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

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

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

Benefits after termination of coverage

You may be totally disabled on the date coverage ends on your account. If so, benefits for covered expenses will be provided to treat the condition that caused the total disability on the same basis as if coverage had continued with no change until the date you are no longer totally disabled or for up to 12 months from the date your coverage ends, whichever is earlier. This does not apply if the services are covered under another group health plan or Medicare.

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

Call the Prescription Drug Program administrator if you need more information about benefits after termination of coverage.

Recovery of overpayments and subrogation

Recovery of overpayments

On occasion, a payment will be made to you when you are not covered, for a service that is not covered, or in an amount that is more than proper. When this happens, the problem will be explained to you and you must return the amount of the overpayment within 60 days after receiving notification.

Right to offset

If the Prescription Drug Program makes a claim payment to you or on your behalf in error or you owe the Program money, you must repay the amount owed. Except as otherwise required by law, if the Prescription Drug Program owes you a payment for other claims received, the Program has the right to subtract any amount owed by you from any payment owed to you.

Subrogation and reimbursement

These paragraphs apply when another party (including another insurer) is, or may found to be, responsible for your injury, illness or other condition and the Program has provided benefits related to that injury, illness or other condition. As permitted by applicable state law (unless preempted by federal law), the Prescription Drug Program may be subrogated to all rights of recovery against such party (including your own insurance carrier) for the benefits provided to you under this *Certificate*. Subrogation means that the Program has the right, independently of you, to proceed directly against the other party to recover the benefits the Program provided.

Subject to applicable state law (unless preempted by federal law), the Program may have the right to reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness or condition for which the Prescription Drug Program provided benefits. Under Section 5-335 of the New York General Obligations Law, the Program's right of recovery does not apply when a settlement is reached between a plaintiff and a defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that you did not take any action against the Program's rights or violate any contract between you and the Program. The law presumes that the settlement between you and the responsible party does not include compensation for the cost of health care services for which the Prescription Drug Program provided benefits.

The Prescription Drug Program requests that you notify them within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or to obtain compensation due to an injury, illness or condition sustained by you for which the Prescription Drug Program provided benefits. You must provide all information requested by the Program or the Program's representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Program reasonably requests.

Audits/prescription benefit records

From time to time, the Prescription Drug Program administrator may ask you to verify receipt of particular drugs from network pharmacies or from a mail service pharmacy or the designated specialty pharmacy. These requests are part of the auditing process. Your cooperation may be helpful in identifying fraudulent practices or unnecessary charges to your plan. All such personal information will remain confidential.

Legal action

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

Medical exception process for drugs excluded from the Flexible Formulary (for non-Medicare-primary enrollees)

The Empire Plan includes a medical exception process for non-formulary prescription drugs that are excluded from coverage. Enrollees and their physicians must first evaluate whether covered drugs on the Flexible Formulary are appropriate alternatives for their treatment. After an appropriate trial of formulary alternatives, an enrollee's physician may submit a letter of medical necessity to the Empire Plan Prescription Drug Program administrator, which details the enrollee's formulary alternative trials and any other clinical documentation supporting medical necessity. The physician may fax the exception request (see *Contact Information*, page 130, for details). If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment (and ancillary charge, if applicable) will apply for brand-name drugs.

Note: Drugs that are only approved by the U.S. Food and Drug Administration for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

Appeals

You or another person acting on your behalf may submit an appeal. If a post-service claim (a claim for benefits payment after a prescription drug has been dispensed) or a preservice request for benefits is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal in writing to the Empire Plan Prescription Drug Program (see *Contact Information*, page 130).

Call The Empire Plan and choose the Prescription Drug Program.

Appeal process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. By filing an appeal, you consent to this referral and the sharing of pertinent claims information.

First-level claims review

In the event a claim has been denied, as not medically necessary or as a result of investigational or experimental use of a covered prescription drug, you can request a review of your claim. This request for review should be sent to the attention of the Claims Review Unit at the Empire Plan Prescription Drug Program address (see *Contact Information*, page 130) within 180 days after you receive notice of denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data or comments to support the appeal of the original determination as well as any information that has been requested. A written acknowledgment of your appeal will be sent to you within 15 days after it is received.

For a first-level appeal, the following timeframes apply:

- **Preservice claims** are requests that services or treatments be approved before they have been received. A preservice claim appeal determination is made within 15 days of receipt of the claim appeal and all necessary information.
- **Post-service claims** are requests for services or treatments that have already been received. A post-service claim appeal determination is made within 30 days of receipt of the claim and all necessary information.
- **Expedited/urgent appeal determinations** are made the earlier of two business days of receipt of all necessary information or 72 hours of receipt of your claim appeal.

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

- Detailed reasons for the determination regarding the appeal and the rationale for the determination.
- Notification of your right to a further review (if applicable).

Second-level claims review

If, as a result of the first-level claims review, the original determination of benefits is upheld by the Prescription Drug administrator, in whole or in part, you can request a second-level claims review. A second-level appeal is a voluntary step in the claims review process, and you are **not** required to complete this step before seeking an external appeal. This request should be directed either in writing or by telephone to the Program administrator within 60 days after you receive notice of the first-level appeal determination. When requesting the second-level claims review, you should state the reasons you believe the benefit reduction or denial was improperly upheld and include any information requested by the Program administrator along with any additional data, questions or comments deemed appropriate.

For a second-level appeal, the following timeframes apply:

- **Preservice claims** are requests that services or treatments be approved before they have been received. A preservice claim appeal determination is made within 15 days of receipt of the claim appeal and all necessary information.
- **Post-service claims** are requests for services or treatments that have already been received. A post-service claim appeal determination is made within 30 days of receipt of the claim and all necessary information.

If an appeal involves a clinical matter, appropriate clinical staff as required by New York State law will be responsible for ensuring the appeal is reviewed by an appropriate provider who did not previously review the claim or precertification request. If an appeal involves an administrative matter, it will be reviewed by another employee of the Prescription Drug Program administrator.

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

Appeals involving urgent situations

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

If you are unable to resolve a problem with an Empire Plan Program administrator, you may contact the Consumer Assistance Unit of the New York State Department of Financial Services (see *Contact Information*, page 131).

External appeals

Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Prescription Drug Program administrator has denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug, you or your representative may appeal for review of that decision by an external appeal agent, an independent entity certified by the New York State Department of Financial Services to conduct such appeals.

Your right to appeal a determination that a drug is not medically necessary

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

- The prescription drug must otherwise be covered under the Empire Plan Prescription Drug Program.
- You must have received a final adverse determination through the internal appeal process described previously and the Program administrator must have upheld the denial or you both must agree in writing to waive any internal appeal.

Your right to appeal a determination that a drug is experimental or investigational

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

- The prescription drug must otherwise be covered under the Empire Plan Prescription Drug Program.
- You must have received a final adverse determination through the internal appeal process described previously and, if any new or additional information regarding the prescription drug was presented for consideration, the Prescription Drug Program administrator must have upheld the denial or you both must agree in writing to waive any internal appeal.

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

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

- A drug that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered drug (only certain documents will be considered in support of this recommendation. Your attending physician should contact the New York State Department of Financial Services to obtain current information about what documents will be considered acceptable).
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

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

Your right to appeal that a prescription drug should be covered because you have been diagnosed with what is considered a rare disease

A rare disease is defined as a condition:

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

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

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

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

The external appeal process

If, through the internal appeal process described previously, you have received a final adverse determination upholding a denial of coverage on the basis that the prescription drug is not medically necessary or is an experimental or investigational drug, you have four months from receipt of such notice to file a written request for an external appeal. If you and the Program administrator have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. The Program administrator will provide an external appeal application with the final adverse determination issued through its internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services (see *Contact Information*, page 131). Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Program administrator based its denial, the external appeal agent will share this information with the administrator in order for the Program administrator to exercise its right to reconsider its decision. If the administrator chooses to exercise this right, it will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), the administrator does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your doctor or the Program administrator. If the external appeal agent requests additional information, it will have five additional business days to make a decision. The external appeal agent must then notify you in writing of its decision within two business days.

If your attending doctor certifies that a delay in providing the prescription drug that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Program administrator by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision. If the external appeal agent overturns the Program administrator's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, the Plan will provide coverage subject to the other terms and conditions of the Program.

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

The external appeal agent's decision is binding on both parties. The external appeal agent's decision is admissible in any court proceeding.

You will be charged a fee of \$25 for an external appeal, and the annual limit on filing fees for a claimant within a single year will not exceed \$75. The external appeal application will instruct you on the manner in which you must submit the fee and the fee will be waived if it is determined that paying it would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an external appeal

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

Four-month external appeal deadline

Under New York State law, your completed request for external appeal must be received by the New York State Department of Financial Services within four months (with an additional eight days allowed for mailing) of the date of the final notice of adverse determination of the first-level appeal or the date upon which you receive a written waiver of any internal appeal. The Prescription Drug Program administrator has no authority to grant an extension of this deadline.

Empire Plan Prescription Drug Program Drug Utilization Review (DUR)

Prescription drugs can cure ailments and keep you healthy—often at a cost much lower than surgery or other procedures. They can, however, also cause serious harm when taken in the wrong dosage or in a harmful combination with another drug.

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

This review process generally asks:

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

When you use your card

When you use your Empire Plan Benefit Card at a network pharmacy or a mail service pharmacy or the designated specialty pharmacy and the pharmacist enters the information into the computer, the computer system will review your recent Empire Plan Prescription Drug Program medication history. If a possible problem is found, a warning message will be flashed to your pharmacist.

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

Safety review

In addition, a “behind the scenes” safety review is conducted to identify any potential drug therapy-related problems. If a potential problem is detected, the information is reviewed by a clinical pharmacist who notifies your doctor of the possible risks. If two prescribing doctors are involved, both will be notified of the potential problem.

If, as the result of the DUR, it is determined that a member may be using prescription drugs in a harmful or abusive manner or with harmful frequency, the Plan reserves the right to limit an enrollee to the use of a single network pharmacy, plus the mail service pharmacy or the designated specialty pharmacy. This process helps your doctor make more informed decisions about your prescription drugs.

Refill too soon

A key component of the DUR safety process implemented for this Program is the application of the “refill too soon” (RTS) edit for all claims submitted under the Program. The RTS Program ensures that the Empire Plan Prescription Drug Program provides safety and utilization review across all supply chains, network pharmacy claims, mail service pharmacy or the designated specialty pharmacy claims and non-network pharmacy claims processed for an individual enrollee. Upon processing of an incoming claim, the previous 180 days of an enrollee’s prescription drug claim history are reviewed by the systematic RTS criteria. The RTS edit will cause the claim to reject if the enrollee should have consumed (based on days’ supply) less than 75 percent of their medication on a cumulative basis over the past 180 days. When a claim is rejected, the pharmacist is sent a message indicating the next refill date for the enrollee. Certain drugs that have quantity-level limits, such as erectile dysfunction drugs, have more restrictive RTS limits to comply with the quantity allowed per days’ supply. See *Supply and coverage limits*, page 111, for additional information. The RTS Program will also take into account the cumulative days’ supply that should be on hand.

Confidential service

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

Education Is the Right Prescription

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

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

Contact Information

NYSHIP Online

To learn more about your benefits, including finding Empire Plan providers and updated NYSHIP publications, visit www.cs.ny.gov/employee-benefits. Next, choose your group (M/C; Legislature) and plan (Empire Plan), if prompted.

The Empire Plan

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program.

PRESS ORSAY 1 Medical/Surgical Program *Administered by UnitedHealthcare*

Choose this option for medical/surgical benefits, claims and most appeals; outpatient radiology; certification of home care; medical equipment and supplies; Infertility and Cancer Centers of Excellence or chiropractic or physical therapy benefits; and policy conversions.

Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern Time

TTY: 1-888-697-9054

UnitedHealthcare
P.O. Box 1600
Kingston, NY 12402-1600

External appeals

To request an application from the New York State Department of Financial Services:
1-800-400-8882

Home Care Advocacy Program (HCAP) appeals

Home Care Advocacy Program
P.O. Box 5400
Kingston, NY 12402-5400

Diabetic supplies (except insulin pumps and Medijectors)

Empire Plan Diabetic Supplies Pharmacy
1-888-306-7337

Ostomy supplies

Byram Healthcare Centers
1-800-354-4054

PRESS ORSAY 2 Hospital Program *Administered by Empire BlueCross BlueShield*

(Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.)

Choose this option for hospital benefits and most claims and appeals, preadmission certification of inpatient hospital, skilled nursing facility admissions and Centers of Excellence for Transplant surgeries.

Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern Time

TTY: 1-800-241-6894

Empire BlueCross BlueShield
New York State Service Center
P.O. Box 1407, Church Street Station
New York, NY 10008-1407

Other claims

If the hospital does not deal directly with its local BlueCross Plan:

When filing the claim directly with the local BlueCross Plan, refer the bill to:
Code YLS, Empire BlueCross BlueShield
New York State Service Center
P.O. Box 1407, Church Street Station
New York, NY 10008-1407

Hospitals outside of the United States:

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126

Written appeals

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

External appeals

New York State Department of Financial Services
1-800-400-8882

** Mental Health and Substance Abuse (MHSA) Program
Administered by Beacon Health Options**

Choose this option for mental health and substance abuse benefits and claims, authorization of services and referrals to network providers.

Representatives are available 24 hours a day, seven days a week.

TTY: 1-855-643-1476

Beacon Health Options
P.O. Box 1800
Latham, NY 12110

Written appeals

Beacon Health Options Appeals Department
P.O. Box 1800
Latham, NY 12110

External appeals

New York State Department of Financial Services
1-800-400-8882



Prescription Drug Program
Administered by CVS/caremark

Choose this option for prescription drug benefits and claims, Empire Plan Formulary and the mail service pharmacy.

Representatives are available 24 hours a day, seven days a week.

TTY: 711

General correspondence, prior authorization, grievances

CVS/caremark
Customer Care Correspondence
P.O. Box 6590
Lee's Summit, MO 64064-6590

Mail service pharmacy

CVS/caremark
P.O. Box 2110
Pittsburgh, PA 15230-2110

Claims

Mail completed claim forms to:

The Empire Plan Prescription Drug Program
CVS/caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Medical exception requests for drugs excluded from the Flexible Formulary

Tell your physician to fax these requests to: 1-888-487-9257

Written appeals

Prescription Claim Appeals
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

External appeals

New York State Department of Financial Services
1-800-400-8882

If you are unable to resolve a problem with an Empire Plan Program administrator

Contact The Consumer Assistance Unit of the New York State Department of Financial Services at:

New York State Department of Financial Services
One Commerce Plaza, Albany, NY 12257
1-800-342-3736 Monday through Friday, 9 a.m. to 5 p.m. Eastern Time

NYSHIP HMOs

NYSHIP Health Maintenance Organization (HMO) contact information, including phone numbers, TTY numbers, addresses and websites are available in the *Choices* booklet and on the New York State Department of Civil Service website at www.cs.ny.gov/employee-benefits.

Social Security Administration

Call to enroll in Medicare. Under NYSHIP rules, you and your dependents must be enrolled in Medicare Parts A and B as soon as you or your dependents become eligible for coverage under Medicare that is primary to your Empire Plan coverage. You must be enrolled in Medicare even if you are working for another employer. Retirees, vestees, dependent survivors: Call to enroll three months before your 65th birthday or at any age if you become eligible because of disability or end-stage renal disease. Call for Medicare cards.

1-800-772-1213
TTY: 1-800-325-0778
www.ssa.gov

Medicare Benefits and Claims

Including the Medicare Competitive Bidding Program for durable medical equipment and prosthetic and orthotics supplies.

1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048
www.medicare.gov

Retirement Systems

Call about retirement checks and retirement system benefits.

New York State and Local Retirement System (NYSLRS)

This system comprises the Employees' Retirement System (ERS) and the Police and Fire Retirement System (PFRS).

1-866-805-0990 (outside Albany) toll free
518-474-7736 (Interactive Voice Response line)
www.osc.state.ny.us

Police and Fire Retirement System (PFRS)

518-474-7736 (Interactive Voice Response line)
www.osc.state.ny.us

New York State Teachers' Retirement System (NYSTRS)

1-800-782-0289 (recorded information)
518-447-2666 or 1-800-356-3128
www.nystrs.org

Health Benefits Administrator (fill in)

Name: _____

Phone Number: _____

Email: _____

Employee Benefits Division

518-457-5754 or 1-800-833-4344

Representatives are available Monday through Friday, 9 a.m. to 4 p.m. Eastern Time

New York State Department of Civil Service

Employee Benefits Division

Albany, New York 12239

U.S. Preventive Services Task Force (USPSTF)

For USPSTF recommendations

www.uspreventiveservicestaskforce.org

New York State
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
www.cs.ny.gov/employee-benefits

Important Health Insurance Information:
Empire Plan Certificate for Active Management/
Confidential (M/C) Employees of the State of New York
or the Legislature and for their enrolled dependents;
and for COBRA and Young Adult Option enrollees
M/C Empire Plan Certificate

Change Service Requested

**Please do not send mail or
correspondence to the return
address above. See address
information on page 132.**

**SAVE
—THIS—
BOOK**

Important information about the New York State Health Insurance Program

Updates to this book will be mailed
to you and will also be posted on our
website, www.cs.ny.gov/employee-benefits.
Keep all updates with this book.



NYSHIP
New York State
Health Insurance Program

Reasonable accommodation: It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. If you need an auxiliary aid or service to make benefits information available to you, please contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).