United University Professions

January 1, 2021 Empire Plan Certificate

New York State Health Insurance Program

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

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 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 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/Optum™ Physical Health, which includes Managed Physical Network, Inc. and OptumHealth Care Solutions, LLC, for chiropractic treatment, physical therapy and occupational therapy.
- Center of Excellence for Transplants Program through Empire BlueCross.
- Center of Excellence for Infertility Program through UnitedHealthcare.
- Center of Excellence for Cancer Program through UnitedHealthcare.
- Mental Health and Substance Use Program through Beacon Health Options.
- Prescription drug coverage through CVS Caremark.

Familiarize yourself with The Empire Plan by reading this *Certificate* so you can effectively use the Plan's benefits.

Pay particular attention to the information about the Empire Plan Benefits Management Program, the Home Care Advocacy Program, the Managed Physical Medicine Program, Transplants Program, Infertility Benefits, the Mental Health and Substance Use 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.

Refer to your *Amendments* for changes that may occur to the out-of-network combined annual deductible, combined annual coinsurance maximum and copayments.

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 (ACIP) 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 the 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/Surgical 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.

Combined Out-of-Pocket Limits

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

In-Network Out-of-Pocket Limit

Effective January 1, 2022, the annual out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,650 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $3,050 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Family Coverage

- $11,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $6,100 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Out-of-Network Combined Annual Deductible

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

Each $1,250 deductible will be reduced to $625 per calendar year for employees earning less than $40,210 as of **January, 1 2022**.

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

Combined Annual Coinsurance Maximum

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

Each $3,750 coinsurance maximum will be reduced to $1,875 per calendar year for employees earning less than $40,210 as of **January 1, 2022**.

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

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

Section I: The Empire Plan Benefits Management Program

Hospital, Skilled Nursing Facility and Medical/Surgical 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.

When to use the Benefits Management Program

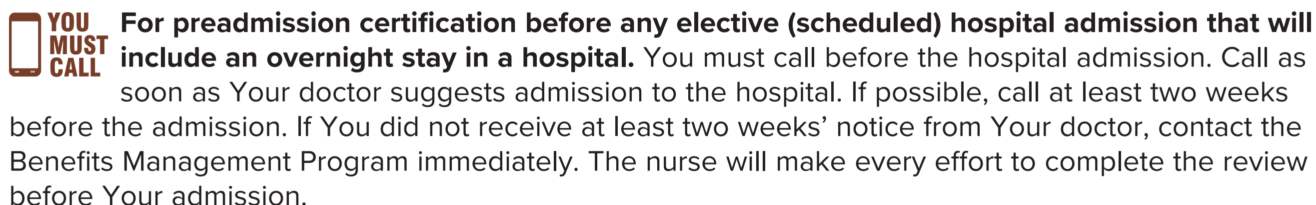
The Empire Plan Benefits Management Program requirements apply when The Empire Plan is Your primary health insurance coverage. (The Empire Plan is primary when it is responsible for paying for health benefits first, before any other group plan, Health Maintenance Organization [HMO] or Medicare is liable 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 other group plan.

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. If possible, call at least two weeks before the admission. 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.

You must call:

- **If You are admitted to the hospital during Your pregnancy due to complications or for any reason 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 13 and 14, 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 do not have to call before the birth of Your child; however, it is recommended You call if You or Your baby are hospitalized for more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery.

You must call the Empire Plan Medical/Surgical 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) scan or nuclear medicine test, unless You are having the test as an inpatient in a hospital (see *Prospective Procedure Review*, page 7, for details).

Who calls?

You, a member of Your family or household, Your doctor or a member of Your doctor's staff may call. **However, You are responsible for ensuring 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 services. Empire Plan enrollees need to evaluate the medical appropriateness of services they receive. Every medical procedure includes some risk, and it also can be unhealthy to be overtreated or undertreated. The costs associated with unnecessary services shrink health benefits dollars, and money spent on unneeded services reduces the pool of money for essential treatment.

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

Read items A. through F. carefully to learn how the Empire Plan Benefits Management Program applies 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.
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent admission.
- Before admission to a skilled nursing facility, as explained in *Preadmission certification for skilled nursing facility admission*, page 6.

You do not have to call before the birth of Your child; however, it is recommended You call if You or Your baby are hospitalized for more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery.

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

You did not follow the preadmission certification requirements if:

- You did not call the Benefits Management Program for preadmission certification of an elective (scheduled) inpatient admission,
- 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.

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 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 Your spouse's 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/Surgical 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.

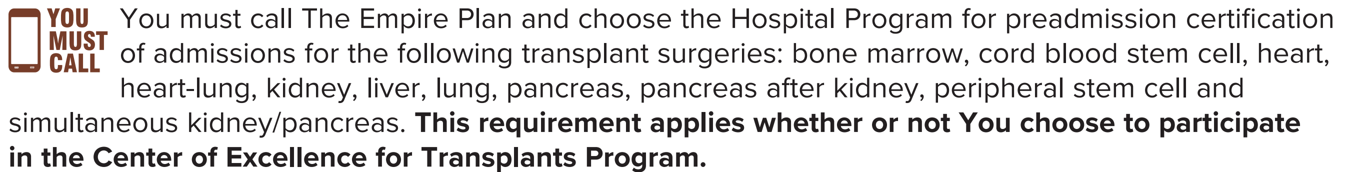
When The Empire Plan is Your primary coverage, skilled nursing facility care is covered if:

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

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 for 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 and dressing, assistance with 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, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell 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

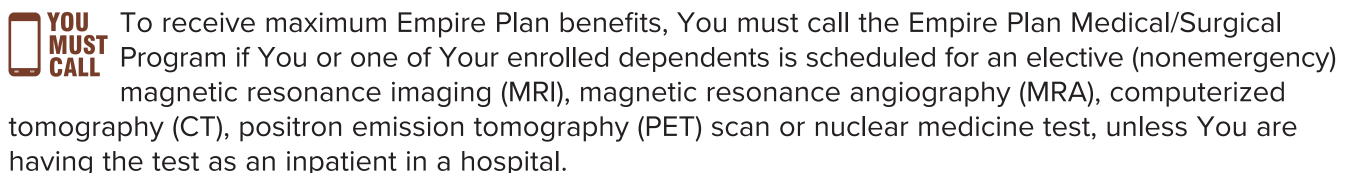
Once You or Your enrolled dependent is hospitalized, the Empire Plan Benefits Management Program will continue to monitor Your progress through the concurrent review program. The goal of concurrent review is to encourage the appropriate use of inpatient care. If the Benefits Management Program determines 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 149).

C. Discharge planning

If You or Your enrolled dependent needs special services after hospitalization, the Hospital Program discharge planning unit nurses, working with hospital discharge planners, can help. 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 *Home Care Advocacy Program (HCAP)*, page 70.

D. Prospective Procedure Review



To receive maximum Empire Plan benefits, You must call the Empire Plan Medical/Surgical 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) scan 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 may call Your doctor to discuss their recommendation. If the Medical/Surgical Program Administrator determines that the MRI, MRA, CT, PET scan 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 MRI, MRA, CT, PET scan 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.

An MRI, MRA, CT, PET scan 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 MRI, MRA, CT, PET scan 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 usual and customary rate or $250. In addition, You must meet Your combined annual deductible and You must pay the coinsurance and any provider charges above the usual and customary rate. (The coinsurance is the 20 percent You pay for covered services by nonparticipating providers, up to an annual maximum.)

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 best choices for Yourself and Your covered dependents.

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 familiar with benefits available under The Empire Plan and local and regional health care resources 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 available community resources.

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

Voluntary specialist consultant evaluation

You may request a voluntary specialist consultant evaluation for any scheduled procedure. Call The Empire Plan and choose the Medical/Surgical Program for a list of up to three physicians whose specialty is similar to Your doctor's. 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 be admitted to the hospital for the procedure, You must call The Empire Plan and choose the Hospital Program for preadmission certification.

F. Future Moms Program

The Future Moms Program is an Empire Plan Benefits Management Program that offers special help for pregnant women. This includes pregnant women acting as surrogates. To enroll, call The Empire Plan and choose the Hospital Program. 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 a safe delivery. See the following for details.

Future Moms Program

When Your primary coverage is The Empire Plan, You can sign up for the Future Moms Program—a pregnancy support program designed just for expectant moms. Participation in the Program is voluntary but recommended. The Benefits Management Program helps identify possible problems and works with mother and doctor throughout the pregnancy. This partnership can make a significant difference.

To enroll in the Future Moms Program, call The Empire Plan and choose the Hospital Program. Call as soon as You know You are pregnant (during the first month is best).

When You sign up for the Future Moms Program You receive:

- Your own maternal health coach.
- Access to a registered nurse helpline 24 hours a day, seven days a week.
- Helpful and informative materials throughout Your pregnancy on topics including Your baby's development and growth; fitness and nutrition; feeding Your baby; choosing the right doctor; and infant safety.
- Breastfeeding support from a lactation consultant, counselor or registered dietitian on LiveHealth Online.

Initial Assessment: A Benefits Management Program maternity registered nurse 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.

If You are identified as high risk, You can elect to participate in the High Risk Pregnancy Program. You will be contacted at least once a month by a Future Moms Program nurse for ongoing assessments. Your participation is voluntary, and calls will be scheduled at Your convenience.

Shortly after You join the Future Moms Program, You will receive a welcome kit in the mail that includes the *Mayo Clinic Guide to Healthy Pregnancy* book and a Maternity Care Diary.

28 Weeks: A Future Moms Program nurse will call to check in with You again at around week 28 of Your pregnancy. That nurse will discuss Your most recent checkup, confirm that You have had the appropriate tests and screenings and answer any questions You have about prenatal tests, delivery options, caring for Your baby or any other health concerns You may have.

After this phone call, You will receive another packet with helpful information about Your third trimester and preparing for labor, with topics including delivery options and postpartum depression.

After Delivery: Your Future Moms Program nurse will call You two to four weeks after Your delivery to check on how You and the baby are doing. Your nurse can also offer additional support if You have the "baby blues" or are suffering from postpartum depression. After this call, You will receive a birth kit that includes information on infant care and home safety.

Remember to contact Your Health Benefits Administrator within 30 days of the date of birth to add Your newborn to Your Empire Plan coverage. Refer to Your *General Information Book* for additional information.

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 for the results of the review.

Call again

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 the scheduled date of Your admission changes, 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) Scan or Nuclear Medicine Test Postponed: If the Benefits Management Program approved Your procedure but You and Your doctor decide to postpone it for more than 45 days, You must call again for another review when the procedure is rescheduled.

MRI, MRA, CT, PET Scan or Nuclear Medicine Test Repeated: If You followed Prospective Procedure Review requirements for a procedure and it is scheduled to be repeated, You must call the Benefits Management Program again.

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

The Benefits Management Program does not replace the Empire Plan Mental Health and Substance Use Program. Call The Empire Plan and choose the Mental Health and Substance Use Program before seeking care for mental health and substance use 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 use related. If You cannot decide, call either the Mental Health and Substance Use Program or the Benefits Management Program for help determining 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/Surgical Program, depending on the services to be precertified (see *Contact Information*, page 149). 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) scan or nuclear medicine test.

Section II: The Empire Plan Hospital Program 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 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 or additional out-of-pocket expenses.

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 mean 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 mean 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*, page 15).

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. 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 to enroll, which dependents are eligible 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 *Exclusions and limitations*, page 28, and *If You Qualify for Medicare*, page 33, 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, 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 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 penalties and copayments, as applicable.

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

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

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

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. This includes maternity admissions for You when acting as a surrogate. 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 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 *Exclusions and limitations*, page 28, 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. **Exception:** Skilled nursing benefits are available if the enrollee is actively working and Medicare entitlement for the enrollee or an enrolled dependent is due to end-stage renal disease (ESRD).

Outpatient MRI, MRA, CT, PET scans 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 are available. You must comply with the requirements of the Empire Plan Benefits Management Program if The Empire Plan is Your primary coverage. Please see *Exclusions and limitations*, page 28, 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 department visits are subject to a $100 copayment, outpatient surgical expenses are subject to a $95 copayment, diagnostic outpatient services (diagnostic radiology, including diagnostic laboratory tests) are subject to a $50 copayment and physical therapy services are subject to a $25 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 covered 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 covered 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 Plan covers 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 $3,750 for the enrollee and $3,750 for the enrolled spouse/domestic partner. All dependent children have a combined annual coinsurance maximum of $3,750.

  Each $3,750 coinsurance maximum will be reduced to $1,875 per calendar year for employees earning less than $40,210 as of **January 1, 2022**.

  Coinsurance amounts incurred under the Basic Medical Program and Non-Network Hospital and Mental Health and Substance Use (MHSU) coverage are applied to the combined annual coinsurance maximum. Copayments for participating provider and network MHSU 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 of 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.

For a list of Empire Plan Network Hospitals, hospices and skilled nursing facilities, go to NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Find a Provider. 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. If The Empire Plan is Your primary coverage, benefits are subject to the requirements of the Empire Plan Benefits Management Program.

- **In a Hospital.** The term "hospital" means only an institution that fully meets 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 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 the ambulance service is owned, operated and billed by the admitting or transferring hospital. For information regarding ambulance providers that are not owned, operated and billed by a hospital, call the Medical/Surgical Program (see *Contact Information*, page 149).

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.

- **Birthing Center.** The Hospital Program will pay for the hospital services described in *Hospital Services Covered* on this and 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 23, 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 16. 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 provided 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 after surgery, such as removal of sutures and check-up visits. See *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, page 59, for more information on Surgery.
- **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 a doctor. 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.

- **Preadmission and Presurgical Testing.** All the following conditions must be met:
  A. The tests are ordered by a physician as a preliminary step toward Your 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 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 from the date of the surgery.

  You pay a $25 copayment for each visit to the outpatient department of a Network Hospital or the greater of 10 percent of charges or $75 at a Non-Network Hospital for physical therapy when covered by the Hospital Program. This payment is in addition to any other payment, either copayment or coinsurance, applied to outpatient services rendered on the same day.
- **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 79]). 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.
- **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** You are covered for mammograms, which may be provided by breast tomosynthesis (i.e., 3-D mammograms), for the screening of breast cancer as follows:
  A. One baseline mammogram for covered persons 35 through 39 years of age.
  B. Upon the recommendation of the covered person's Provider, an annual screening mammogram for covered persons 35 through 39 years of age if Medically Necessary.
  C. One screening mammogram annually for covered persons age 40 and over.

  If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) with a history of breast cancer, the Hospital Program covers mammograms as recommended by the treating Provider. However, in no event will more than one preventive screening per year be covered.

  Mammograms for the screening of breast cancer are not subject to copayment when provided by a participating provider.

Additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and magnetic resonance imaging (MRIs) are covered. Screening and diagnostic imaging for the detection of breast cancer are not subject to copayment when provided by a participating provider.

- **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.

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

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

- **Urgent Care.** Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Service must be rendered by a provider that has been identified by the Hospital Program as hospital-based. For a list of identified hospital-based providers, go to NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Find a Provider. Urgent care may also be rendered in a physician's office or urgent care center. An urgent care center is a licensed facility (other than a hospital) that provides urgent care. See *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance* for more information regarding coverage for services rendered in a physician's office or urgent care center.

- **Observation Care.** Observation services are hospital outpatient services provided to help a physician decide whether to admit or discharge You following surgery performed in the outpatient department of the hospital or during an emergency department visit. These services include the use of a bed or periodic monitoring by nursing or other licensed staff. If associated with surgery, the outpatient surgery copayment will apply. If associated with an emergency department visit, the emergency department copayment will apply.

Copayment for emergency care

You must pay the first $100 in charges (copayment) for emergency care in a hospital emergency department. See *Outpatient Hospital Care*, page 17, for emergency care. Hospitals may require payment of this charge at the time of service.

The emergency department copayment covers use of the facility for **emergency care** and services of the attending emergency department 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 65, in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, if You receive bills for hospital emergency department service from these providers.

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

Copayment for outpatient hospital services

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

Hospital outpatient services include:

- Diagnostic radiology.
- Diagnostic laboratory tests.

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

When copayments do not apply

You will not have to pay the copayments for:

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

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

Telemedicine Benefit

LiveHealth Online

LiveHealth Online is a telemedicine benefit that helps You and Your covered dependents access health care services remotely. You can stay home and have a telephone or video visit with a board-certified doctor or licensed therapist on Your smartphone, tablet or personal computer.

When scheduling a visit with LiveHealth Online, it is important to enter Your name and Empire Plan ID number exactly as it appears on Your card, otherwise the claim may not be processed correctly.

To begin the registration process for remote care, go to www.empireblue.com/nys and select the link to LiveHealth Online. If You need assistance with the registration process or have questions, call LiveHealth Online at 1-888-LiveHealth (1-888-548-3432). LiveHealth Online has representatives available 24 hours a day, seven days a week. You may also call The Empire Plan and choose the Hospital Program for assistance with accessing LiveHealth Online.

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. under 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 help with transferring, eating, dressing, bathing, toileting and other such related activities, 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. (**Exception:** Skilled nursing benefits are available if the enrollee is actively working and Medicare entitlement for the enrollee or an enrolled dependent is due to end-stage renal disease [ESRD].) 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 accredited as a skilled nursing facility by one or more of the following: The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or The Board of Certification/Accreditation,
- Undergoes or has undergone within the prior 36 months a site visit survey and receives a passing score by a designated independent external entity (DIEE) using that external entity's previously established and the Joint Commission's Nursing Care Center (NCC)-approved criteria,
- Is certified as a participating skilled nursing facility under Medicare or

- In the absence of the above criteria, meets the following criteria:

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

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

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

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 23, 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.

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

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 aide.
  - 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. (Skilled nursing facility care is limited to 120 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 120-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 17, 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 also does not apply to hospice care. See *Hospice Care*, page 22, for more information.

Hospital Coverage outside of the United States

Hospital care under The Empire Plan is available worldwide. To maximize Your benefits and minimize Your out-of-pocket cost for care in a hospital outside of the United States, locate a BlueCross BlueShield Global Core participating facility in Your area. Visit www.bcbsglobalcore.com or call 1-800-810-BLUE (1-800-810-2583) to locate a participating facility. If calling from outside of the continental United States, You can make a collect call to 1-804-673-1177.

If You know in advance that You will need care while out of the country, You should locate a BlueCross BlueShield Global Core participating facility in Your area prior to receiving care. If You receive inpatient care at a participating facility that was arranged through the BlueCross BlueShield Global Core Service Center, You may not be responsible for paying the full hospital costs at the time services are rendered and the provider will file the claim for You.

For all outpatient care, or if You have already paid the hospital, You must submit a claim and the Hospital Program will reimburse You directly for covered, medically necessary services (see *Filing and Payment of Hospital Claims*, page 36).

In the event of an emergency, You should go to the nearest hospital emergency department. However, if The Empire Plan determines that Your visit was not a medical emergency, Your expenses will not be covered under the Hospital Program. In this case, You can submit Your expenses to the Empire Plan Medical/Surgical Program to be considered for reimbursement.

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 and Your transplant services are preauthorized by the Hospital Program Administrator.

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 as of the date of publication of this *Certificate*. As additional Centers of Excellence are added to the Transplants 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 Distinction Centers for Transplant (BDCT), a national network of transplant providers who have demonstrated quality care, treatment expertise and, overall, better patient results.
- 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.
- Expenses associated with donors must be submitted to the donor's health insurance plan first before benefits can be considered under The Empire Plan. Documentation from the donor's health insurance plan must be provided. Donor expenses are considered only after a donor is identified and selected as a positive match.

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.

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

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

Infertility benefits, including Qualified Procedures, 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; however, up to three in-vitro fertilization (IVF) cycles will be covered and will not be subject to the $50,000 lifetime maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles is also not subject to the $50,000 lifetime maximum. For more information about travel, lodging and meal expenses associated with the Infertility Benefits Program, call the Medical/Surgical Program or see *Centers of Excellence Travel Allowance*, page 27.

Prior authorization is not required. However, it is recommended You call the Medical/Surgical Program Administrator to verify coverage of infertility benefits, or to find out how using a Center of Excellence offers You the highest level of benefits for infertility care.

Your coverage for this benefit will not be affected by Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity.

What is covered

Basic infertility services

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

- Artificial/intrauterine insemination.
- Inpatient and/or outpatient surgical or medical procedures, performed in the hospital, which 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.

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 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.

Surrogacy and Donor Costs

Costs and services to a donor in facilitating surrogacy are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and limitations*, page 27, for more information.

However, Maternity services are covered for You when acting as a surrogate. For services covered, see *Inpatient Hospital Care* on page 16 and *Outpatient Hospital Care* on page 17.

Qualified Procedures

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.

Qualified Procedures obtained in the inpatient or outpatient departments of a hospital are covered under the Hospital Program. The following Qualified Procedures are covered under The Empire Plan:

- Assisted reproductive technology (ART) procedures including:
  - In vitro fertilization (IVF) and embryo placement. An IVF cycle is all treatment that starts when:
    - Preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or
    - Medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer
  - 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:
    - Microsurgical epididymal sperm aspiration (MESA)
    - Testicular sperm extraction (TESE)
- Sperm, egg and/or inseminated egg, processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of eggs, sperm or embryos). When infertility could be the result of a medical treatment, see *Fertility preservation services* below.

Maximum lifetime benefit

Benefits paid for Qualified Procedures 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. However, up to three IVF cycles will be covered and will not be subject to the $50,000 lifetime maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles is also not subject to the $50,000 lifetime maximum.

For more information about travel, lodging and meal expenses associated with the Infertility Benefits Program, call the Medical/Surgical Program or see *Centers of Excellence Travel Allowance*, page 27.

Fertility preservation services

Fertility preservation is the process of saving or protecting eggs, sperm or embryos so that a person can use them to have biological children in the future. Standard fertility preservation services are covered when a medical treatment will directly or indirectly lead to infertility. Examples of such medical treatments include surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Fertility preservation services are not subject to the Lifetime Maximum of $50,000 per covered individual. **Note:** Costs and services to a donor providing eggs or sperm to create embryos are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and limitations*, page 27, for more information.

Infertility: Exclusions and limitations

Charges for the following expenses are not covered or payable:

- Qualified Procedures when You do not have a diagnosis of infertility.
- 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.** See *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance* for coverage that is provided for these fertility drugs.
- Costs for and relating to surrogacy. However, maternity services are covered for You when acting as a surrogate. For services covered, see *Inpatient Hospital Care* on page 16 and *Outpatient Hospital Care* on page 17.
- Any donor compensation or fees charged in facilitating a pregnancy.
- Any charges for services provided to a donor in facilitating a pregnancy.
- Psychological evaluations and counseling. See *Section IV: The Empire Plan Mental Health and Substance Use 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*.

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, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

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

Hospital Program General Provisions

Exclusions and limitations

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 16), *Outpatient Hospital Care* (page 17), *Skilled Nursing Facility Care* (page 21), *Hospice Care* (page 22), *Center of Excellence for Transplants Program* (page 24) or *Infertility Benefits* (page 25), 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 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 40, 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 with 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 provided 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 if You bring a lawsuit against the person who caused Your injury or condition and 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 33, 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 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 41. 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 Use, 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

Please refer to *Section IV: The Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, which contains all of the Mental Health and Substance Use benefits that are covered under The Empire Plan. You may also contact the Mental Health and Substance Use Program Administrator (see *Contact Information*, page 151) if You have any questions.

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 17.

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.

Please refer to the instructions under *Appeals*, page 39, 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 (the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year.
   - If 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.
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, the Plan has 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 enrolls in a non-NYSHIP Medicare Advantage plan, You will be automatically disenrolled from NYSHIP coverage.

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 for 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 Medicare 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 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 will be responsible for applicable Hospital Program copayments.

  If the hospital does not deal directly with the Empire Plan Hospital Program Administrator, submit a hospital claim form and the Explanation of Benefits form You received from Medicare to the Empire Plan Hospital Program Administrator. Covered expenses will then be processed for payment. See *Filing and Payment of Hospital Program Claims*, page 36, 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 154).

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. These benefits will be supplemented by the benefits You enrolled for under Medicare.

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

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

F. **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 day 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 could 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 for payment. If You receive hospital services outside of New York State, have the hospital submit its bills to the local BlueCross plan (the plan in the area where You received services) and instruct the local BlueCross plan to refer the bill to Empire BlueCross, Code YLS (see *Contact Information*, page 150, 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 33, 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 payment for medically necessary covered services received in a Non-Network Hospital is made directly to You and You are responsible to pay the hospital.
   - For services outside of the United States, Empire BlueCross will pay You directly, unless You indicate otherwise.

Follow the directions below to file Your claim:

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

  If the hospital will not file the claim, You should file the claim directly with the local BlueCross plan (the plan in the area where You received services) within 18 months of Your discharge from the hospital or outpatient service. Send the local BlueCross and/or BlueShield plan an itemized bill showing the services rendered, the dates on which those services were received, the diagnosis and Your Empire Plan identification number. See *Contact Information*, page 150, for instructions on where to send the bill. If the bill is for emergency department medical services, You must also include information about the condition or symptoms that led You to seek emergency department treatment.

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

- **Hospital Outside of the United States:** Send an original itemized hospital bill in English or with a translation, if possible, a completed International Claim Form, located on the BlueCross BlueShield Global Core website, and Your Empire Plan identification number to the address listed in the *Contact Information* section, page 150.

  In order to process Your claims according to the guidelines of The Empire Plan, Empire BlueCross 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 Denies Your Claim for Benefits.** If Empire BlueCross 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 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 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 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 the Program Administrator has all the information necessary to make a determination regarding a preadmission or Prospective Procedure Review, the Program Administrator 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 the Program Administrator needs additional information, it will request it within three business days. You or Your provider will then have 45 calendar days to submit the information. The Program Administrator 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 the Program Administrator's 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 the Program Administrator has all information necessary to make a determination, it 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 the Program Administrator needs additional information, it will request it within 24 hours. You or Your provider will then have 48 hours to submit the information. The Program Administrator will make a determination and provide notice to You and Your provider, by telephone and in writing, within 48 hours of the earlier of the 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 the Program Administrator needs additional information, it will request it within one business day. You or Your provider will then have 45 calendar days to submit the information. The Program Administrator 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 the receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, the Program Administrator 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 time frames specified previously for preadmission or Prospective Procedure Review of urgent claims.

If the Program Administrator has already approved a course of treatment, it will not reduce or terminate the approved services unless it has 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 the Program Administrator has all information necessary to make a determination regarding a retrospective claim, it 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 the Program Administrator needs additional information, it will request it within 30 calendar days. You or Your provider will then have 45 calendar days to submit the information. The Program Administrator will make a determination and provide notice to You and Your provider within 15 calendar days of the earlier of the receipt of the information or the end of the 45-day time period. If the Program Administrator has all information necessary to make a decision but fails to make a determination within the required time frames, this will be deemed an adverse determination, subject to an internal appeal. If upon internal appeal, the Program Administrator does not make a decision within the required time frames, the adverse determination will be reversed.

Notice of adverse determination

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 the 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 the Program Administrator 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. The Program Administrator will send notices of determination to You (or Your designee) and, as appropriate, to Your health care provider. If the Program Administrator provides a notice of adverse determination but does not attempt to consult with Your provider who recommended the service, Your provider may request a reconsideration of the adverse determination.

Grievance Procedures

Grievances

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

Filing a Grievance

You may contact the Hospital Program by writing to the Hospital Program Administrator (see *Contact Information*, page 150) to file a grievance. You may submit an oral grievance in connection with a denial of a covered benefit determination by calling the Hospital Program (see *Contact Information*, page 149). You or Your designee has up to 180 calendar days to file the grievance from when You receive the decision You are asking to have reviewed.

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

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

Grievance determination

Qualified personnel will review Your grievance, or, if it is a clinical matter, a licensed, certified or registered health care professional will review. **For an issue relating to a medical necessity or experimental or investigational determination, see the *Utilization Review Guidelines* section, page 38.**

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

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

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

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

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

Second-level grievance/administrative appeal

If You are not satisfied with the resolution of Your grievance, You or Your designee may file a second-level grievance/administrative appeal by writing to or calling the Hospital Program Administrator (see *Contact Information*, page 150). Urgent appeals may also be filed by phone. You have up to 60 business days from receipt of the grievance determination to file a second-level grievance/administrative appeal.

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

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

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

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

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

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

Assistance

If You remain dissatisfied with the Hospital Program Administrator's second-level administrative appeal determination, or at any other time You are dissatisfied, You may contact the New York State Department of Financial Services (see *Contact Information*, page 153).

If You need assistance filing a grievance or administrative appeal, You may also contact the State Independent Consumer Assistance Program (see *Contact Information*, page 153).

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 151. 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 the Program Administrator will provide You with a written decision within 30 days of Your request.

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

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 the Program Administrator will provide You with a written decision within 30 days of Your request.

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 153.

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 153] to obtain current information about which 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 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 151). 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, then contact the Hospital Program Administrator (see *Contact Information*, page 150) or call The Empire Plan.

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, Center of Excellence for Infertility Program 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 provided 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.)

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, the Provider submits the charges for You to the Medical/Surgical Program Administrator who pays the Provider directly in accordance with the Schedule of Allowances. The Program sends You an Explanation of Benefits form telling You which benefits the Participating Provider received. You do **not** have to pay the Participating Provider for remaining charges after Your Copayment for Covered Services or submit a claim form. Using Participating Providers is convenient for You and helps keep the cost of The Empire Plan at a reasonable level.

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.

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

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

Special Medical/Surgical Programs

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, occupational therapy and physical therapy, the Basic Medical Provider Discount Program, the Center of Excellence for Infertility Program and the Center of Excellence for Cancer Program. Special benefits and requirements apply under these programs, as explained in each section.

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 Usual and Customary Rate and for any penalties incurred under the Benefits Management Program. See *How, When and Where to Submit Claims*, page 87, 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.

Definitions

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

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

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

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

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

F. **Coinsurance** means the difference between the Usual and Customary Rate 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.

G. **Combined Annual Coinsurance Maximum** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each Calendar Year, after the annual Deductible has been met, for Covered Medical Expenses incurred under the Basic Medical, non-network Hospital and non-network Mental Health and Substance Use (MHSU) Programs.

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

   Each $3,750 coinsurance maximum will be reduced to $1,875 per Calendar Year for employees earning less than $40,210 as of **January 1, 2022**.

   Coinsurance amounts incurred under the Basic Medical, non-network Hospital and non-network MHSU programs are applied to the Combined Annual Coinsurance Maximum. Copayments for Participating Provider and network MHSU practitioner services also count toward the Combined Annual Coinsurance Maximum.

   The annual Deductible does not count toward the Combined Annual Coinsurance Maximum. Any expenses above the Usual and Customary Rate or the Scheduled Pharmaceutical Amount do not count. Copayments made to network Hospital facilities do not count toward the Combined Annual Coinsurance Maximum. Expenses for ambulance services and expenses under the Home Care Advocacy Program (HCAP), Managed Physical Medicine Program and the Benefits Management Program do not count toward the Combined Annual Coinsurance Maximum, nor do any penalties under the Benefits Management Program or HCAP.

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

above the Usual and Customary Rate or Scheduled Pharmaceutical Amount and for any penalties under the Benefits Management Program.

H. **Combined Annual Deductible** means the amount You must pay in total, each Calendar Year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program (HCAP) expenses and/or non-network Mental Health and Substance Use (MHSU) Program expenses before benefits will be paid under these components of the Plan.

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

Each $1,250 deductible will be reduced to $625 per Calendar Year for employees earning less than $40,210 as of **January 1, 2022**.

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

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

I. 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.

J. Your **Copayment** is the first $25 that You are required to pay for certain services by Participating Providers, the first $30 in a participating Urgent Care Center or the first $50 in a participating outpatient surgical location.

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

L. **Covered Medical Expenses or Covered Services** means the covered charges for covered medical services performed or supplies or Pharmaceutical Products prescribed by a Physician or other Provider, under the terms and conditions of this *Certificate*, except as otherwise provided below. A Covered Medical Expense or Covered Service is incurred on the date the service, supply or Pharmaceutical Product is received by You. In order for a charge to be a Covered Medical Expense or Covered Service, the service, supply or Pharmaceutical Product must be provided by a Provider as defined in item AX. on page 52.

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

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

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

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.

- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Medical/Surgical Program Administrator accepts.

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

M. **Covered Percentage**

1. Under the Participating Provider Program, the **Covered Percentage** is **100 percent** of the Schedule of Allowances, after Your Copayment.
2. Under the Basic Medical portion of this Plan, the **Covered Percentage** for Covered Medical Expenses is **80 percent** of the Usual and Customary Rate or the Scheduled Pharmaceutical Amount except:
   a. As provided under *Prospective Procedure Review*, page 7; under the *Home Care Advocacy Program (HCAP)*, page 70; under *Guaranteed access* for the *Managed Physical Medicine Program*, page 76; and under *Infertility Benefits*, page 77; and
   b. The **Covered Percentage becomes 100 percent** of the Usual and Customary Rate or the Scheduled Pharmaceutical Amount once the Combined Annual Coinsurance Maximum is met.
3. For infertility benefits, expenses are paid the same as for other medical conditions: The Covered Percentage for Basic Medical Program services is 80 percent of the Usual and Customary Rate. Under the Participating Provider Program, the Covered Percentage is 100 percent of scheduled allowances after Your Copayments. However, You have no Copayment at a Center of Excellence for Infertility. Certain benefits are subject to a Lifetime Maximum as indicated in the *Infertility Benefits* section, page 78.

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

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

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

P. **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.

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

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

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

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

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

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

W. **Home Care Advocacy Program (HCAP) Network Allowance** means the amount HCAP Network Providers have agreed to accept as payment in full for services they render to You.

X. **Home Care Advocacy Program (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 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.

Y. A **Home Care Advocacy Program (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 HCAP. 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.**

Z. **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.

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

AB. **Hospital** is defined in the Hospital Program section of this book on page 12.

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

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

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

AF. The **Lifetime Maximum** of the Basic Medical portion of this Plan and the Managed Physical Medicine Program is unlimited. The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is $50,000 (including any applicable travel, lodging and meal allowances) per covered person under the Empire Plan Hospital and Medical/Surgical Programs. However, up to three in vitro fertilization (IVF) cycles will be covered, not subject to the $50,000 Lifetime Maximum (including the covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for those cycles). After the three cycles are completed, additional Qualified Procedures (including covered travel, lodging and meal allowances when using a Center of Excellence for Infertility) are subject to the $50,000 Lifetime Maximum.

AG. **Managed Physical Medicine Program (MPMP) Network Allowance** means the amount Network Providers have agreed to accept as payment in full for services they render to You, including Your Copayments, under MPMP.

AH. **Managed Physical Medicine Program (MPMP) Network Providers** are those eligible Providers who have an agreement in effect to accept Your Copayment plus the MPMP Network Allowance as payment in full for chiropractic treatment, physical therapy and occupational therapy under MPMP.

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

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

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

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

AK. **Managed Physical Network (MPN) Network Allowance** means the payment for Covered Services agreed to by the Provider and OptumHealth Care Solutions, LLC (Optum) or Optum's affiliates.

AL. **Managed Physical Network (MPN) Non-Network Allowance** means the amount paid for a service that is determined by the Medical/Surgical Program Administrator and is applied according to established guidelines. The Non-Network Allowance is used by the Program Administrator as a basis for determining the amount of benefits You are entitled to receive under Non-Network coverage.

AM. **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.

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

AO. **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.

AP. **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 78. A directory of Participating Providers (which includes Provider locations) is available on NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Find a Provider.

AQ. **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.

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

AS. 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.

AT. **Predeterminations** are requests that services or treatments be approved before they have been received (also known as preservice claim determinations). See the *Preservice claim determinations* section on page 88 for more information.

AU. **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 additional information on Preventive Care Services, see the *Preventive Care* section on page 60 or *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Using Your Benefits. You can also go to www.hhs.gov/healthcare/rights/preventive-care.

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

AW. **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.

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

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

AZ. **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.

BA. **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 1st. 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.

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

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

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

BE. **Telehealth** means a Provider's use of electronic information and communication technologies, including telephone or video using smart phones or other devices, to deliver Covered Services to You when You and Your Provider are in different locations.

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

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

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

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

The determination of the Usual and Customary Rate for a service or supply is made by the Medical/Surgical Program Administrator. In making the determination of the Usual and Customary Rate for a service or supply, the Medical/Surgical Program Administrator uses data sources including the benchmarking database maintained by FAIR Health©, a nonprofit organization approved by the State of New York. The Empire Plan generally utilizes FAIR Health© rates at the 90th percentile to determine the allowable amount. You may estimate out-of-pocket costs for out-of-network services by contacting Your Provider for the amount that will be charged or You may go to www.fairhealthconsumer.org to determine the Usual and Customary Rate for these services in Your geographic area or zip code.

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

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

BJ. The word **You** or **Your** 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*.

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 Provider, an **additional** Copayment(s) will apply.

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

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

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

You pay only Your $30 Copayment for **Urgent Care Clinic** visits. You pay only Your $50 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).

Combined out-of-pocket limit

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

In-network out-of-pocket limit

Effective January 1, 2022, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage:

- $5,650 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs.

Family Coverage:

- $11,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs.

Finding Participating Providers

UnitedHealthcare has a nationwide network of Providers. To learn whether a Provider participates in the UnitedHealthcare network for The Empire Plan:

- Always ask Your Provider if they are a Participating Provider and accepting new patients before You receive services.
- Call The Empire Plan and choose the Medical/Surgical Program or
- Check *The Empire Plan Participating Provider Directory* on NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Find a Provider.

When You use a Participating Provider, the Medical/Surgical Program Administrator will pay for the covered medical services listed under *What is covered under the Participating Provider Program* on page 56. 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 network benefits for Covered Services provided by primary care Physicians and Specialists (listed as follows) in New York State or in the counties of Fairfield and Litchfield in Connecticut; Berkshire in Massachusetts; Bergen, Hudson, Middlesex, Passaic, Sussex and Union in New Jersey; Bradford, Erie, McKean, Pike, Potter, Susquehanna, Tioga, Warren and Wayne in Pennsylvania; and Addison, Bennington, Chittenden, Grand Isle and Rutland in Vermont, when You do not have access to a network Provider within a reasonable distance from Your residence (see chart that follows).

To receive network benefits, enrollees must call The Empire Plan and select the Medical/Surgical 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 within 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	Urban: 15 miles
Suburban: 15 miles	Suburban: 25 miles
Rural: 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	Internal Medicine	Pediatrics
General Practice		Obstetrics/Gynecology
Specialties		
Allergy	Gastroenterology	Otolaryngology
Anesthesia	General Surgery	Pulmonary Medicine
Cardiology	Hematology/Oncology	Radiology
Dermatology	Neurology	Rheumatology
Emergency Medicine	Ophthalmology	Urology
	Orthopedic Surgery	

What is covered under the Participating Provider Program

Under the Participating Provider Program, Covered Medical Expenses include charges for the following services:

A. **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.

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

C. **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.

D. **Dental Care** – You are covered for the following limited dental services, subject to Copayment, including Pharmaceutical Products and appliances dispensed by a Provider:

   - For the correction of damage caused by an accident, provided the services, supplies or Pharmaceutical Products are received within 12 months of the trauma and while You are covered under this Plan.
   - For the correction of damage caused by a medical illness, congenital disease or anomaly for which You are eligible for benefits under this Plan.
   - For charges incurred for temporomandibular joint (TMJ) syndrome for the following conditions that are consistent with the diagnosis of organic pathology of the joint: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections and traumatic injuries.
   - For TMJ, Covered Services, supplies or Pharmaceutical Products include diagnostic exams, X-rays, models and testing, injections of medications and trigger-point injections.

E. **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.

F. **Diagnostic Imaging for the Detection of Breast Cancer** – See *Preventive Care*, page 60, for information regarding benefits for mammography and diagnostic imaging for the detection of breast cancer.

G. **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.

H. **Gender Dysphoria Treatment** – Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery is covered when Your behavioral health provider, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a written psychological assessment documenting that You have a diagnosis of gender dysphoria, the capacity to make a fully-informed decision and to consent for treatment and are at least 18 years of age.

   Any other associated surgeries, services and procedures, including those done to change Your physical appearance to more closely conform secondary sex characteristics to those of Your identified gender are covered when Your behavioral health provider, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a determination

of Medical Necessity and confirms that You have a diagnosis of gender dysphoria, have the capacity to make a fully-informed decision and consent for treatment and are 18 years of age or older. While not required, a Predetermination review, also known as a preservice claim determination, is available (see the *Preservice claim determinations* section on page 88 for more information).

I. **Infertility Treatment** – See *Infertility Benefits*, page 77, 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 covered in-Hospital surgery or maternity care. You are not covered if the anesthesia services are administered by Your surgeon, by Your surgeon's assistant or by a Hospital employee.

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

L. **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.

M. **Maternity Care** – You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, for complications of pregnancy and maternity services, including prenatal care, for You when acting as a surrogate. 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. Perinatal depression screening for pregnant and postpartum patients is also covered.

   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. Prenatal ultrasounds/sonograms are not classified under the federal Patient Protection and Affordable Care Act (PPACA) or United States Preventive Services Task Force (USPSTF) as preventive services and may be subject to cost share.

N. **Miscellaneous Services and Supplies** – When the Hospital Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

   - Diagnostic laboratory procedures when the specimen is sent to the Hospital.
   - 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.
   - Speech therapy.
   - Occupational therapy.
   - Physical therapy.
   - Audiology exam and services.
   - Cardiac rehabilitation.
   - Pulmonary rehabilitation.
   - Nutritional/diabetic counseling.
   - Respiratory therapy.

- Durable medical equipment.
- Orthotics and prosthetics.
- Inpatient hospital facility charges (when Hospital Program benefits have been exhausted).
- Preventive services including radiology and laboratory services.

When the Prescription Drug Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Contraceptive drugs and devices that require injection, insertion or other Provider intervention when the drugs/devices are dispensed in a Provider's office.

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. However, if Your participating Physician refers laboratory testing to a Nonparticipating Provider without Your knowledge, You may be eligible for participating level benefits. See *Miscellaneous Provisions*, page 90, for more information about surprise bills or contact the Medical/Surgical Program for more information.

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

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

See *Preventive Care* on page 60.

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

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

S. **Podiatry** – You are covered for the services of a podiatrist except for routine care of the feet, subject to Copayment.

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

U. **Prostheses and Orthotic Devices** – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs. There is no Copayment for the prosthesis and/or orthotic device when You use a Participating Provider. Replacements, when functionally necessary, are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot is covered only when it is Medically Necessary and custom made.

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

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

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

X. **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.

Y. **Speech Therapy** – You are covered, subject to Copayment(s), for the services of a speech therapist or speech-language pathologist when all of the following apply:

- Such services are prescribed by a qualified Provider,
- Treatment is Medically Necessary and
- The Provider is currently licensed in the state where the service is rendered.

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

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

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

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

AB. **Urgent Care Center** – Services received at an Urgent Care Center that has an agreement in effect with the Medical/Surgical Program on the date of Your visit are covered, subject to Copayment.

Preventive Care

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

For more information on preventive care services, see *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Using Your Benefits. You can also go to www.hhs.gov/healthcare/rights/preventive-care. The Medical/Surgical Program may provide upon request a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF and immunizations recommended by ACIP. The Medical/Surgical Program covers the following:

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

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

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

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

- **Adult Immunizations** – Adult immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention are covered, not subject to Copayment, when received from a Participating Provider. Covered adult immunizations include influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chickenpox), tetanus immunizations, human papillomavirus (HPV) immunizations, meningitis immunizations and herpes zoster (shingles) immunizations (Shingrix®). Shingrix® is paid in full for enrollees and dependents age 50 and older. There is no benefit for vaccines received from an out-of-network Provider.

- **Bone Mineral Density Measurements or Testing** – Bone mineral density measurements or tests and devices approved by the FDA. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Coverage of prescription drugs is subject to the Prescription Drug Program section of this *Certificate*. You will also qualify for coverage of bone mineral density measurements and testing if any of the following apply:

  - You were previously diagnosed as having osteoporosis or having a family history of osteoporosis.
  - You have symptoms or conditions indicative of the presence or significant risk of osteoporosis.
  - You are on a prescribed drug regimen posing a significant risk of osteoporosis.
  - You have lifestyle factors that pose a significant risk of osteoporosis.
  - Your age, gender or other physiological characteristics pose a significant risk for osteoporosis.

The Program also covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayment when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all the listed services, such as devices.

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

  The Medical/Surgical Program also covers vasectomies, subject to Copayment, and services related to the reversal of elective sterilization, which is not classified as preventive care under applicable laws and is subject to Copayment.

- **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** – You are covered for mammograms, which may be provided by breast tomosynthesis (i.e., 3-D mammograms), for the screening of breast cancer, as follows:
  - One baseline screening mammogram for covered persons 35 through 39 years of age.
  - Upon the recommendation of the covered person's Provider, an annual screening mammogram for covered persons 35 through 39 years of age if Medically Necessary.
  - One screening mammogram annually for covered persons age 40 and over.

  If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) with a history of breast cancer, the Medical/Surgical Program covers mammograms as recommended by the treating Provider. However, in no event will more than one preventive screening per year be covered.

  Mammograms for screening of breast cancer are not subject to Copayment when provided by a Participating Provider.

  Additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and magnetic resonance imaging (MRIs), are covered. Screening and diagnostic imaging for the detection of breast cancer are not subject to Copayment when provided by a Participating Provider.

- **Well-Baby and Well-Child Care** – Well-baby and well-child care, which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics (AAP) is covered. The Medical/Surgical Program also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the AAP recommendations of well-child visits referenced above permits one well-child visit per Calendar Year, the Medical/Surgical Program will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to enrollees from birth through age 19 and is not subject to Copayment.

- **Well-Woman Examinations** – Well-woman examinations, which consist of a routine gynecological examination, breast examination and annual cervical cancer screening, including laboratory and diagnostic services in connection with evaluating the cervical cancer screening, are covered. You are

also covered for preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. For a list of the covered preventive services, see *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Using Your Benefits. You can also go to www.hhs.gov/healthcare/rights/preventive-care. This benefit is not subject to Copayment when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above.

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

Transitional Care

Continuity of care: When Your Provider leaves the network

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

To continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated allowance that was in effect just prior to the termination of the Program Administrator's relationship with the Provider. The Provider must also agree to provide necessary medical information related to Your care and adhere to the Program Administrator's policies and procedures, including those for assuring quality of care, and for obtaining preauthorization and a treatment plan approved by the Medical/Surgical Program Administrator. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being rendered by a Participating Provider. You will be responsible only for any applicable in-network cost-sharing. Please note that if the Provider was terminated by the Medical/Surgical Program Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

Transition of care: New course of treatment

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

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

Basic Medical Program

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 70, and the *Managed Physical Medicine Program*, page 75. 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 Usual and Customary Rate, 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 Usual and Customary Rate and
- You have met Your Combined Annual Deductible.

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

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

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

Assignment of benefits to a Nonparticipating Provider is not permitted

You may not assign any monies due under this *Certificate* to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill (see *Miscellaneous Provisions*, page 90, for more information about surprise bills). Assignments will be made to Hospitals and for ambulance services as long as the ambulance service has a contract in effect with the Medical/Surgical Program and to Providers in the Empire Plan Basic Medical Provider Discount Program. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise required by applicable law.

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

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 Usual and Customary Rate 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 Usual and Customary Rate or Scheduled Pharmaceutical Amount. The Covered Percentage becomes 100 percent of the Usual and Customary Rate 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 $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per Calendar Year for employees earning less than $40,210 as of **January 1, 2022**.

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 Usual and Customary Rate or the Scheduled Pharmaceutical Amount**.

C. **Covered Basic Medical Expenses**

Covered Medical Expenses under the Basic Medical Program are defined as the Usual and Customary Rate 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 *Definitions*, item AM., page 50. No more than the Usual and Customary Rate 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 *Definitions*, item L., page 47.

How to estimate Nonparticipating Provider costs

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

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

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

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

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

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 the following limited dental services, including Pharmaceutical Products and appliances dispensed by a Provider:

   - For the correction of damage caused by an accident, provided the services, supplies or Pharmaceutical Products are received within 12 months of the trauma and while You are covered under this Plan.
   - For the correction of damage caused by a medical illness, congenital disease or anomaly for which You are eligible for benefits under this Plan.
   - For charges incurred for temporomandibular joint (TMJ) syndrome for the following conditions that are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by X-ray: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections and traumatic injuries.
   - For TMJ, Covered Services, supplies or Pharmaceutical Products include diagnostic exams, X-rays, models and testing, injections of medications and trigger-point injections.

E. **Diabetes Education Centers** – If You have a diagnosis of diabetes, You are covered for Medically Necessary visits for self-management.

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

Services that are provided by other specialty Physicians or other Providers in a Hospital emergency department are paid in full.

If the emergency services, including inpatient services when admitted though the emergency department within New York State, are provided by other Nonparticipating Providers (e.g., surgeons), the charges will be paid in full.

The Empire Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from Nonparticipating Providers at a network facility without their knowledge. See *Miscellaneous Provisions*, page 90, for more information about surprise bills or contact the Medical/Surgical Program for more information.

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

H. **Gender Dysphoria Treatment** – Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery is covered when Your behavioral health provider, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a written psychological assessment documenting that You have a diagnosis of gender dysphoria, the capacity to make a fully-informed decision and to consent for treatment and are at least 18 years of age.

   Any other associated surgeries, services and procedures, including those done to change Your physical appearance to more closely conform secondary sex characteristics to those of Your identified gender are covered when Your behavioral health provider, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a determination of Medical Necessity and confirms that You have a diagnosis of gender dysphoria, have the capacity to make a fully-informed decision and consent for treatment and are 18 years of age or older. While not required, a Predetermination review, also known as a preservice claim determination, is available (see the *Preservice claim determinations* section on page 88 for more information).

I. **Gynecologic Exams** – You are covered for a minimum of two gynecologic exams each year, as well as any services resulting from such exams.

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

K. **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 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.

L. **Infertility Treatment** – See *Infertility Benefits*, page 77, for information regarding benefits for the treatment of infertility.

M. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** – You are covered for mammograms, which may be provided by breast tomosynthesis (i.e., 3-D mammograms), subject to deductible and coinsurance for the screening of breast cancer, as follows:

- One baseline screening mammogram for covered persons age 35 through 39.
- Upon the recommendation of the covered person's Provider, an annual screening mammogram for covered persons 35 through 39 years of age if Medically Necessary.
- One screening mammogram annually for covered persons age 40 and older.

If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) has a history of breast cancer, the Medical/Surgical Program covers mammograms as recommended by the treating Provider. However, in no event will more than one preventive screening per year be covered.

If You are eligible for the Routine Health Exam benefit, mammograms are not subject to Deductible or Coinsurance. See item AA. *Routine Health Exams for Active Employees*, page 68.

Additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and magnetic resonance imaging (MRIs), are covered. Screening and diagnostic imaging for the detection of breast cancer are subject to Deductible and Coinsurance when provided by a Nonparticipating Provider.

N. **Mastectomy Bras** – When prescribed by a Physician or other Provider, mastectomy bras, including replacements when functionally necessary, are covered.

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

P. **Maternity Care** – You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, for complications of pregnancy and maternity services, including prenatal care, for You when acting as a surrogate. 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. Perinatal depression screening for pregnant and postpartum patients is also covered.

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

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

Q. **Miscellaneous Services and Supplies** – When the Hospital Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Diagnostic laboratory procedures when the specimen is sent to the Hospital.
- 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.
- Speech therapy.
- Occupational therapy.
- Physical therapy.
- Audiology exam and services.
- Cardiac rehabilitation.
- Pulmonary rehabilitation.

- Nutritional/diabetic counseling.
- Respiratory therapy.
- Durable medical equipment.
- Orthotics and prosthetics.
- Inpatient hospital facility charges (when Hospital Program benefits have been exhausted).
- Laboratory services (including pathology).

When the Prescription Drug Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Contraceptive drugs and devices that require injection, insertion or other Provider intervention when the drugs/devices are dispensed in a Provider's office.

R. **Modified Solid Food Products** – When prescribed by a Physician or other Provider, modified solid food products (MSFPs) are covered. This benefit is not subject to Deductible or Coinsurance.

Modified solid food products include products that are low in protein or that contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.

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

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

U. **Physicians** – Services of Physicians and other Providers who perform Covered Medical Services are covered.

V. **Podiatrists** – Services of duly licensed podiatrists for the treatment of diseases, injuries and malformation of the foot are covered, except that those treatments or supplies listed in items J. and U. of the *Exclusions and limitations* section under *Medical/Surgical Program General Provisions* (see pages 81 and 82) are not Covered Medical Expenses.

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

X. **Prosthesis and Orthotic Devices** – One prosthesis and/or orthopedic appliance commonly known as an orthotic device, per affected body part meeting an individual's functional needs, is covered.

Replacements, when functionally necessary, are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot is covered under the Basic Medical Program only when it is Medically Necessary and custom made.

Y. **Prosthetic Wigs** – 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.

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

AA. **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.

AB. **Routine Newborn Child Care** – Physician's or other Provider's services are covered for newborn care for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care

provided shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. These benefits are not subject to Deductible or Coinsurance.

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

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

AE. **Specialist Consultations** – Charges for a consultation with a Specialist who is a Nonparticipating Provider are considered under the Basic Medical Program.

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.

AF. **Speech Therapy** – You are covered for Speech Therapy under the same conditions as the Participating Provider Program, subject to Deductible and Coinsurance.

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

Multiple surgical procedures performed during the same operative session may be subject to a reduction in reimbursement. Multiple surgical procedures shall be reimbursed in an amount not less than the Usual and Customary Rate for the most expensive procedure performed. Less expensive procedures shall be reimbursed in an amount at least equal to 50 percent of the Usual and Customary Rate for these secondary procedures. You will be responsible for amounts charged by a Provider in excess of this rate.

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

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

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

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

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

Out-of-Network Referral

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

This requirement applies to Empire Plan-primary enrollees residing in the United States and United States territories. If You require access to a certain Provider, contact the appropriate Empire Plan Program Administrator (see *Contact Information*, page 149).

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

If the Plan approves the request, You must use this approved out-of-network provider and Covered Services will be paid at the in-network benefit level with only the applicable network Copayment owed. You are responsible for contacting the Provider to arrange care. If the Plan denies the request, benefits for Covered Services received from a Nonparticipating Provider are available under out-of-network benefit provisions, subject to Deductible and Coinsurance. You may also request an External Appeal through the NYS Department of Financial Services (see *Contact Information*, page 149).

Home Care Advocacy Program (HCAP)

The Home Care Advocacy Program (HCAP) is The Empire Plan program for home care services, certain Durable Medical Equipment and medical supplies that are associated with Durable Medical Equipment (see the definition for item A., *Durable Medical Equipment,* page 71). 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. Refer to *Non-network benefits*, page 74, for coverage of Durable Medical Equipment when You do not use HCAP.

Network coverage: Paid-in-full benefit

You must call The Empire Plan and choose the Medical/Surgical 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 150). (For insulin pumps and Medijectors, You must call HCAP for authorization.) For ostomy supplies, call the designated ostomy supply company (see *Contact Information*, page 150). You must provide the network supplier with a copy of the Provider's order for the diabetic or ostomy supplies.

Important Notes:

- If Medicare is Your Primary Coverage, You must use a Medicare contract Provider.
- **The Medicare Durable Medical Equipment and Prosthetic and Orthotics Supplies (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 154). 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 H. in the *Impact of Medicare on This Plan* section, page 85.

What is covered

The following home care services and/or Durable Medical Equipment or supplies related to Durable Medical Equipment are covered under HCAP when prescribed by Your doctor and determined to be Medically Necessary by the Medical/Surgical Program Administrator.

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

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

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

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

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

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

C. **Communication Devices** – You are covered for a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, the rental or purchase of assistive communication devices is covered when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through typical means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. You are covered only for devices that generally are not useful to a person in the absence of communication impairment. You are not covered for items, such as,

but not limited to, a laptop, a desktop or tablet computers. You are covered for software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Program Administrator will determine whether the device should be purchased or rented.

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

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

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

Refer to *Non-network benefits*, page 74, for coverage of skilled nursing services when You do not use HCAP.

Refer to *Section II: The Empire Plan Hospital and Related Expenses Certificate of Coverage*, item Q., page 17, for coverage of a maternity home care visit following early discharge after delivery.

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

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

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

Examples of formulas not covered are:

- Electrolyte-containing enteral fluids
- Self-blenderized formulas

G. **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 which 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 preauthorization 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 $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per Calendar Year for employees earning less than $40,210 as of **January 1, 2022**.

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/Surgical 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/Surgical 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 22, 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 149) or call The Empire Plan and choose the Medical/Surgical Program.

For information on Medical/Surgical Program claim Appeals, see *How, When and Where to Submit Claims*, page 87.

Managed Physical Medicine Program

The Managed Physical Medicine Program (MPMP) is administered by Optum™ Physical Health, which includes Managed Physical Network, Inc. (MPN) and OptumHealth Care Solutions, LLC.

Coverage for chiropractic treatment, physical therapy and occupational 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, physical therapy and occupational therapy. You will receive a significantly lower level of benefits when You choose non-network Providers.

The Empire Plan MPMP covers Medically Necessary services typically performed by a chiropractor, physical therapist or occupational therapist. Other Providers, such as osteopaths, 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

MPMP benefits and responsibilities apply to You whenever You seek coverage for physical therapy, chiropractic treatment or occupational therapy, 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.

Network benefits

You pay a $25 Copayment for each office visit for chiropractic treatment, physical therapy or occupational therapy when You choose a Network Provider. You pay an additional $25 Copayment for related radiology and diagnostic laboratory services billed by the Network Provider. If a 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.

$25 Copayments when You use a Network Provider

You do not need to call MPMP before Your visit. Your 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, physical therapy or occupational therapy directly and ask if the Provider is in the network. Or, You may call The Empire Plan and choose the Medical/Surgical Program. Network Providers are also listed in *The Empire Plan Participating Provider Directory*.

Guaranteed access

What If There Are No Network Providers in Your Area? You are guaranteed that network benefits will be available to You under MPMP. Call The Empire Plan and choose the Medical/Surgical Program. MPMP will make arrangements for You to receive Medically Necessary chiropractic treatment, physical therapy or occupational therapy, and You will pay only Your $25 Copayment for each visit. But, You must call first and You must use the Provider with whom MPMP has arranged Your care.

Non-network benefits

If You receive chiropractic treatment, physical therapy or occupational therapy from a non-network Provider when MPMP 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 MPMP annual deductible of $250 before MPMP will pay for Covered Services. 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 MPMP or the MPN Network Allowance for such services, whichever is less. This deductible is separate from other Plan deductibles.

Coinsurance Applies: After satisfying the MPMP deductible, You will be reimbursed up to a maximum of 50 percent of the Network Allowance for covered Medically Necessary services from a non-network Provider.

Your $250 deductible and amounts applied to Coinsurance under the MPMP do not count toward Your Combined Annual Deductible and Coinsurance Maximum.

If MPMP 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 MPMP 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/Surgical Program, then select the MPMP from the automated telephone system menu if You have questions about Your coverage for chiropractic treatment, physical therapy or occupational therapy.

Appeals: 180-day deadline

To Appeal MPMP's determination, submit a written Appeal within 180 days to Managed Physical Network, Inc. (see *Contact Information*, page 150). For information on the Medical/Surgical Program claims Appeal, see *Appeals*, page 96.

Infertility Benefits

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

Infertility benefits, including Qualified Procedures, 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; however, up to three in vitro fertilization (IVF) cycles will be covered and will not be subject to the $50,000 Lifetime Maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles are also not subject to the $50,000 Lifetime Maximum.

Prior Authorization is not required. However, it is recommended You call the Medical/Surgical Program Administrator to verify coverage of infertility benefits or to find out how using a Center of Excellence offers You the highest level of benefits for infertility care.

By using Participating Providers, You minimize Your out-of-pocket costs.

Your coverage for this benefit will not be affected by Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity.

What is covered

Basic infertility services

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

- Patient education/program orientation
- Diagnostic testing
- Ovulation induction/hormonal therapy
- Artificial/intrauterine insemination
- 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.

Surrogacy and Donor Costs

Costs and services to a donor in facilitating surrogacy are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and limitations*, page 78, for more information.

However, maternity services, including prenatal care, are covered for You when acting as a surrogate. See *Maternity Care*, page 57, for Participating Provider coverage or page 67 for Basic Medical coverage.

Qualified Procedures

Qualified Procedures are specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility. The following Qualified Procedures are covered under The Empire Plan:

- Assisted reproductive technology (ART) procedures, including:
  - In vitro fertilization (IVF) and embryo placement. An IVF cycle is all treatment that starts when:
    - Preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or
    - Medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer

  - 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:
    - Microsurgical epididymal sperm aspiration (MESA)
    - Testicular sperm extraction (TESE)
- Sperm, egg and/or inseminated egg, processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of eggs, sperm or embryos). When infertility could be the result of a medical treatment, see *Fertility preservation services* below.

Maximum lifetime benefit

Benefits paid for Qualified Procedures 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. However, up to three IVF cycles will be covered and will not be subject to the $50,000 Lifetime Maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles is also not subject to the $50,000 Lifetime Maximum.

Fertility preservation services

Fertility preservation is the process of saving or protecting eggs, sperm or embryos so that a person can use them to have biological children in the future. Standard fertility preservation services are covered when a medical treatment will directly or indirectly lead to infertility. Examples of such medical treatments include surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Fertility preservation services are not subject to the Lifetime Maximum of $50,000 per covered individual. **Note:** Costs and services to a donor providing eggs or sperm to create embryos are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and limitations* below for more information.

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; Qualified Procedures; and fertility preservation services. Benefits for infertility treatment and fertility preservation services at a Center of Excellence for Infertility are payable in full. 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 (e.g., laboratory or pathology tests).

Infertility: Exclusions and limitations

Charges for the following expenses are **not** covered or payable:

- Qualified Procedures when You do not have a diagnosis of infertility.
- 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 the Medical/Surgical Program. Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under The Empire Plan. See *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance* for coverage that is provided for these fertility drugs.

- Costs for and relating to surrogacy. However, maternity services, including prenatal care, are covered for You when acting as a surrogate. See *Maternity Care*, page 57, for Participating Provider coverage or page 67 for Basic Medical coverage.
- Any donor compensation or fees charged in facilitating a pregnancy.
- Any charges for services provided to a donor in facilitating a pregnancy.
- Psychological evaluations and counseling. See *Section IV: The Empire Plan Mental Health and Substance Use 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 and limitations* in the *Medical/Surgical Program General Provisions* section, page 80.

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 the 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/Surgical 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/Surgical Program and then Cancer Resource Services to enroll in the Program. You are encouraged to call and renew Your case annually.

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 receive covered infertility services from a Center of Excellence, 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, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

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

Medical/Surgical Program General Provisions

Exclusions and limitations

Charges for the following services, supplies and/or Pharmaceutical Products are not Covered Medical Expenses:

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

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

C. **Cosmetic Services.** Cosmetic services, Pharmaceutical Products or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child, which has resulted in a functional defect. You are covered for services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this *Certificate*. Cosmetic surgery does not include surgery determined to be Medically Necessary. Also excluded are services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs, with the exception of a diagnosis of gender dysphoria. Refer to *What is covered under the Participating Provider Program*, page 56, and *What is covered under the Basic Medical Program (Nonparticipating Providers)*, page 65, for limited coverage of reconstructive surgery.

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

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

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

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

- It is determined by the Program Administrator that the experimental or investigational service at the time of the determination:
    - Is proven 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 98. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, only the costs of services, supplies or Pharmaceutical Products required to provide treatment to You according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of nonhealth-care services or Pharmaceutical Products, the costs of managing research or costs not otherwise covered by The Empire Plan for nonexperimental or noninvestigational treatments provided in connection with such clinical trial.

H. **Family Member Provided Services.** Services, supplies or Pharmaceutical Products provided by Your parent, sibling, spouse/domestic partner or children.

I. **Food Supplements and Vitamins.** Dietary food supplements or vitamins that are not Covered Medical Expenses. **Exception:** Modified solid food supplements and enteral formulas are covered as described on pages 68 and 72 of this *Certificate*.

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

K. **Government Facility Services.** Services, supplies or Pharmaceutical Products provided in a veterans' facility or other services or Pharmaceutical Products furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under The Empire Plan were not in effect. However, this exclusion will not apply to services, supplies or Pharmaceutical Products provided in a medical center or Hospital operated by the U.S. Department of Veterans Affairs for a non-service-connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

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

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

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

O. **Mental Health and Substance Use.** Expenses for mental health or substance use services, supplies and Pharmaceutical Products, including alcoholism. Refer to *Section IV: The Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, which contains all of the Mental Health and Substance Use benefits that are covered under The Empire Plan. You may also contact the Mental Health and Substance Use Program Administrator (see *Contact Information*, page 151) if You have any questions.

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

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

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

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

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

U. **Orthopedic Shoes and Other Devices.** Orthopedic shoes and other supportive devices and services or Pharmaceutical Products for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations. However, a Medically Necessary custom-made orthopedic appliance, commonly known as an orthotic device, used to support, align, prevent or correct deformities or to improve the function of the foot, is covered as outlined in the *Participating Provider* and *Basic Medical Program* sections.

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

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

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

Y. **Vision Services.** Eyeglasses or contact lenses or exams and eye refractions to prescribe them, except as described in the list of Covered Medical Expenses outlined in the *Basic Medical Program* section, page 64.

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

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

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

Coordination of Benefits (COB)

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 Usual and Customary Rate 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, including student health plans
  - 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 Usual and Customary Rate 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 on page 85.

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

   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 Usual and Customary Rate or the Scheduled Pharmaceutical Amount as defined in the *Definitions* section, pages 53 and 52.

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.

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

Coverage

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 enrolls in a non-NYSHIP Medicare Advantage plan, You will be automatically disenrolled from NYSHIP coverage.

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 Usual and Customary Rate or the Scheduled Pharmaceutical Amount as defined in the *Definitions* section, pages 53 and 52.

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

E. **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.

F. **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.

G. **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.**

H. If Medicare is Your primary plan and You live in an area that participates in the Medicare Durable Medical Equipment, Prosthetics and Orthotics Supply Competitive Bidding Program and use equipment or supplies included in the Program (or get the items while visiting one of these areas), You must use a Medicare contract supplier. If You live in these areas (or get these items while visiting them) and don't use a Medicare contract supplier, Medicare will not pay for the item and Your Empire

Plan benefits will be reduced by the amount Medicare would have paid if You had used a contract Provider. In order to maximize Your benefits, it is important for You to know if You're in an area that is affected by this Medicare program. For more information, You can contact Medicare (see *Contact Information*, page 154). If You need additional assistance locating a Medicare contract supplier, contact the Home Care Advocacy Program (HCAP).

How The Empire Plan calculates benefits when Medicare is Primary

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

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

Before Empire Plan benefits are paid:

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

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

How, When and Where to Submit Claims

How

A. If You go to a Participating 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 HCAP approved, You may obtain a claim form from the Empire Plan Medical/Surgical Program Administrator or on NYSHIP Online (see *Contact Information*, page 150). From the NYSHIP Online homepage, select Forms, then Medical/Surgical Program and the applicable form. Deadlines apply for claim submissions (see *When* section).

   Have the doctor or other Provider fill in all the information asked for 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 asked for 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, 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 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, the Statement of Payment from the Hospital Program Administrator and/or the Medicare Summary Notice should be sent to the general UnitedHealthcare address listed in the *Contact Information* section, page 149. Or, You may email using UnitedHealthcare's secure email link: https://nyrmo.optummessenger.com/public/opensubmit or fax forms to 845-336-7716.

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

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/ Surgical Program.

If You do not speak English or are deaf or speech-impaired, You can receive assistance. Contact The Empire Plan and choose the Medical/Surgical 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 149, 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 grievance pursuant to the *Grievance Procedures* section, page 95.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see pages 96 through 101.

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 70] or Prospective Procedure

Review for MRI, MRA, CT, 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 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 conversion 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

If Your coverage under this Plan ends for any of the stated causes, 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.

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

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.

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 149).

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

Miscellaneous Provisions

Protection from Surprise Bills

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

What is a surprise bill?

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

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

What is not a surprise bill?

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

If You have questions about whether a bill meets this definition, call the New York State Department of Financial Services (see *Contact Information*, page 153) or go to www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills.

Additional information

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

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit UnitedHealthcare's website at www.myuhc.com for a copy of the form. You must mail a copy of the assignment of benefits form to Your Health Care Professional and to UnitedHealthcare at the address listed in the *Contact Information* section, page 149.

Independent dispute resolution process

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

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

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 cannot do Your usual duties.

Call the Medical/Surgical Program Administrator 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*.

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.

Confined on date of coverage cancellation

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

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 91).

Recovery of overpayments and subrogation

Recovery of overpayments

On occasion, a payment could 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.

Refund of overpayments

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

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

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

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

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 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/Surgical Program.

Utilization Review Guidelines

If the Program Administrator has all the information necessary to make a determination regarding a preadmission or Prospective Procedure Review, the Program Administrator 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 the Program Administrator needs additional information, it will request it within three business days. You or Your Provider will then have 45 calendar days to submit the information. The Program Administrator 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 the Program Administrator's 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 the Program Administrator has all information necessary to make a determination, it 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 the Program Administrator needs additional information, it will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. A determination will be made and notice will be provided to You and Your Provider, by telephone and in writing, within 48 hours of the earlier of the receipt of the information or the end of the 48-hour time period.

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

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

The Medical/Surgical Program Administrator does not compensate or provide financial incentives to its employees or reviewers for determining that services are not Medically Necessary. The Program Administrator has developed guidelines and protocols to assist employees or reviewers with this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the Medical/Surgical Program (see *Contact Information*, page 149).

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 the Program Administrator needs additional information, it will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. A determination will be made and notice will be provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of the earlier of the receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, the Program Administrator 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 time frames specified previously for preadmission or Prospective Procedure Review of urgent claims.

If the Program Administrator has already approved a course of treatment, it will not reduce or terminate the approved services unless it has 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 the Program Administrator has all information necessary to make a determination regarding a retrospective claim, it 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 the Program Administrator needs additional information, it will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to submit the information. A determination will be made and notice will be provided to You and Your Provider within 15 calendar days of the earlier of the receipt of the information or the end of the 45-day time period. If the Program Administrator has all information necessary to make a decision but fails to make a determination within the required time frames, this will be deemed an adverse determination, subject to an internal appeal. If upon internal appeal, the Program Administrator does not make a decision within the required time frames, the adverse determination will be reversed.

Notice of adverse determination

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 the 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 the Program Administrator 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. The Program Administrator will send notices of determination to You (or Your designee) and, as appropriate, to Your health care Provider.

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

If the Program Administrator receives a request for coverage of home health care services following an inpatient Hospital admission, the Program Administrator will notify You (or Your designee) and Your Provider of its 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 the Program Administrator receives a request for home health care services and all necessary information prior to Your discharge from an inpatient Hospital admission, it will not deny coverage for home health care services, either on the basis of Medical Necessity or for failure to obtain prior authorization, while the decision on the request is pending.

Grievance Procedures

Grievances

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

Filing a Grievance

You may contact the Medical/Surgical Program by writing to the Medical/Surgical Program Administrator (see *Contact Information*, page 149) to file a Grievance. An *Empire Member Services Request Form* is available at www.myuhc.com to assist You with writing a Grievance. You may submit an oral Grievance in connection with a denial of a covered benefit determination by calling the Medical/Surgical Program (see *Contact Information*, page 149). You or Your designee has up to 180 calendar days to file the Grievance from when You receive the decision You are asking to have reviewed.

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

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

Grievance determination

Qualified personnel will review Your Grievance, or, if it is a clinical matter, a licensed, certified or registered Health Care Professional will review. **For an issue relating to a Medical Necessity or experimental or investigational determination, see the *Utilization Review/Clinical Appeal process* section, page 96.**

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

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

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

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

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

Second-level Grievance/administrative Appeal

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file a second-level Grievance/administrative Appeal by writing to or calling the Medical/Surgical Program Administrator (see *Contact Information*, page 149). Urgent Appeals may also be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file a second-level Grievance/administrative Appeal.

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

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

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

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

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

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

Assistance

If You remain dissatisfied with the Medical/Surgical Program's Administrator's second-level administrative Appeal determination, or at any other time You are dissatisfied, You may contact the New York State Department of Financial Services (see *Contact Information*, page 153).

If You need assistance filing a Grievance or administrative Appeal, You may also contact the State Independent Consumer Assistance Program (see *Contact Information*, page 153).

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, preauthorization 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 149).

Utilization Review/Clinical 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 preauthorization 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. **Note:** The four-month time frame for filing an External Appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an External Appeal.

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 153).

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,
- The service is an experimental or investigational treatment,
- The service is a rare disease treatment or
- The Medical/Surgical Program Administrator has denied a preservice out-of-network referral request because there is a geographically accessible in-network Provider with the appropriate training and experience to meet Your health needs.

You or Your representative may Appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Financial Services to conduct such Appeals.

Your right to 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 this 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, 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 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.

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

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

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

The external Appeal process

If, through the internal Appeal process described previously, You have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary, is an experimental or investigational treatment, is a rare disease treatment or for preservice out-of-network referral denials, You have four months from receipt of such notice to file a written request for an External Appeal. 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 149). 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 Plan.

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 Plan 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 Use Program Certificate of Insurance

Program Overview

The Empire Plan Mental Health and Substance Use (MHSU) Program provides comprehensive coverage for Mental Health Care and Substance Use Care, including alcoholism. Beacon Health Options, Inc., is the administrator of the Program.

The 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 113, 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 115, for a complete description.

Coverage

Covered Services for Medically Necessary Mental Health Care and Substance Use Care include, but are not limited to:

- Emergency assessments at all times.
- Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge.
- Alternatives to Inpatient Services at Approved Facilities.
- Outpatient Services.
- Inpatient Services/residential rehabilitation and aftercare following hospital discharge for Substance Use Care.
- Substance use Structured Outpatient Rehabilitation and aftercare.
- Electroconvulsive therapy (ECT).
- Medication management.
- Ambulance services.
- Psychiatric second opinions.
- Applied Behavior Analysis (ABA) with a confirmed diagnosis of Autism Spectrum Disorder.

Important: See Your *General Information Book* along with this *Certificate* for other conditions that may affect this coverage.

If You have questions about benefits available under the Program, You or a member of Your family or household may call the Program Administrator (see *Contact Information*, page 149).

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

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

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

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

Meaning of Terms Used

These are the 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 Autism 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 Addiction Services and Supports of the State of New York or according to the Mental Hygiene Law of New York State. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug use treatment or accredited by the appropriate State agency for the level of care received. Partial hospitalization, intensive outpatient program, day treatment, 23-hour extended bed and 72-hour crisis bed will be considered Approved Facilities if they satisfy the foregoing requirements. Under Network Coverage, residential treatment centers, halfway houses and group homes will be considered Approved Facilities if they satisfy the requirements listed previously and admission is Certified by the Program Administrator. See the definitions for Network Facility and Non-Network Facility for more information. In all cases other than an emergency, the facility must also be approved by the MHSU Program Administrator. **Note:** Services received at an Approved Facility, except emergency services, are subject to a Medical Necessity determination.

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

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

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

F. **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 Use Program.

G. **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 Usual and Customary Rate and the percentage covered. The Plan’s Coinsurance maximum is shared between The Empire Plan’s Basic Medical, Hospital and MHSU Programs. **Note:** Copayments paid to a Network Practitioner count toward meeting Your Plan Coinsurance maximum.

H. **Combined Annual Coinsurance Maximum** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each Calendar Year, for Coinsurance amounts incurred under The Empire Plan's Basic Medical, Hospital and MHSU Programs. Copayments for Network Services also count toward the Combined Annual Coinsurance Maximum. After the Combined Annual Coinsurance Maximum is reached, benefits are paid at 100 percent of Usual and Customary charges for Non-Network Covered Services.

I. **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 MHSU Program Covered 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 lowest 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 Usual and Customary Rate or
- For Approved Facility services, the billed amount for such service.

J. **Concurrent Review** means the Program Administrator's utilization review and medical management program under which it reviews the Medical Necessity of Mental Health Care and Substance Use Care 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 Services review, as described in this *Certificate*.

K. **Copayment** means the amount You are required to pay for Covered Services You obtain from a Network Provider for Outpatient Services under the MHSU Program. Please refer to the *Schedule of Benefits for Covered Services*, page 113, for the exact amount of Copayment. Copayment applies only to Network Coverage and Non-Network emergency department Covered Services. **Note:** Copayments paid to a Network Practitioner count toward meeting Your Plan Coinsurance maximum.

L. **Course of Treatment** means the period of time, as determined by the Program Administrator, required to provide Mental Health Care and Substance Use Care to You for the resolution or stabilization of specific symptoms or a particular disorder. A Course of Treatment may involve multiple Providers.

M. **Covered Expenses** means:

- Under Network Coverage, the Network Allowance for any Medically Necessary Covered Services provided to You by a Network Provider.
- Under Non-Network Coverage, the Usual and Customary charge by a Non-Network Practitioner. These services must be Medically Necessary as defined in item S. on page 105. No more than the Usual 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 113.

Covered Expenses are 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 exclusions is provided on page 115.

N. **Covered Services** means Medically Necessary Mental Health Care and Substance Use Care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.

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

P. **Emergency Care** is care received for an emergency condition. An emergency condition is either:

- 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.

Q. **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.

R. **Intensive Outpatient Program (IOP)** is a freestanding or hospital-based program that provides Medically Necessary Covered 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 Services, residential care or a Partial Hospitalization Program. Intensive Outpatient Programs can be used to treat mental health conditions or substance use disorders or can specialize in the treatment of co-occurring mental health conditions and substance use disorders.

S. **Medically Necessary** means a service that the Program Administrator has certified as:

- 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 use practices and the professional and technical standards adopted by the Program Administrator.

Although a Practitioner may recommend that You 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
- Benefits will be paid under this Program for such service or confinement.

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

- Intended to prevent, diagnose, correct, alleviate or preclude deterioration of a diagnosable condition (most current version of *International Classification of Diseases [ICD]* or *Diagnostic and Statistical Manual [DSM]*) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific and consistent with symptoms and diagnosis.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health care professionals or publications.
- Reflective of a level of service that is safe.
- Not primarily intended for the convenience of the recipient, caretaker or provider.

- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

U. **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 Program.

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

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

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

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

Y. **Network Provider** means either a Network Practitioner or a Network Facility.

Z. **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*.

AA. **Non-Network Facility** means an Approved Facility that has not entered into an agreement with the Program Administrator as an independent contractor to provide Covered Services to You.

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

AC. **Non-Network Provider** means a Practitioner or Approved Facility that has not entered into an agreement with the Program Administrator to provide Covered Services to You.

AD. **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.

AE. **Partial Hospitalization Program** means a freestanding or hospital-based program at an Approved Facility that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for fewer than four hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay.

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

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

AH. **Practitioner** means:

- A psychiatrist.
- A psychologist.

- A licensed mental health counselor (a counselor trained in counseling, psychotherapy and prevention). Counselors work with individuals, couples, families, groups and organizations using brief techniques, such as crisis intervention and solution-focused approaches, or longer-term approaches when treating chronic mental health disorders or disabilities.
- A licensed marriage and family therapist (a therapist trained in individual psychotherapy and family systems to assess and treat mental, emotional and behavioral disorders and address an array of relationship issues within the context of marital/couple, family, relational and group therapy). Therapists provide individual, couple, family, relational and group therapy.
- A licensed clinical social worker in New York State who qualifies for the "R" privilege. If services are performed outside of New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body.
- A Physician Assistant (PA) is licensed and qualified by academic and practical training to provide patient services under the supervision and direction of a licensed Physician who is responsible for the performance of the PA.
- A registered nurse clinical specialist or psychiatric nurse/clinical specialist (an advanced practice nurse who holds a master's or doctoral degree in a specialized area of psychiatric nursing practice).
- A registered nurse practitioner (a nurse with a Master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided and who must be certified and have a practice agreement in effect with a network psychiatrist). Nurse practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols.
- Applied Behavior Analysis (ABA) Provider (a licensed Provider certified as a behavior analyst pursuant to a behavior analyst certification board).
- 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.

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

AJ. **Program** means the Empire Plan Mental Health and Substance Use (MHSU) Program.

AK. **Program Administrator** means the company selected/contracted by the State of New York to administer the Empire Plan MHSU Program. The Program Administrator is Beacon Health Options. 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 MHSU Program.

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

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

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

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

AO. **Structured Outpatient Rehabilitation Program** means a program that provides Substance Use Care and is an operational component of an Approved Facility that is state licensed. If located in New York State, the program must be certified by the Office of Addiction Services and Supports of the State of New York.

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

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

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

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

AQ. **Total Disability** or **Totally Disabled** means that because of a mental health/substance use condition, You, the enrollee, cannot do Your job or Your dependent cannot perform their usual duties.

AR. **Usual 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.

AS. **You/Your** means any Empire Plan enrollee covered by this Program and any dependent member of an enrollee's family who is also covered by The Empire Plan. 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 Services for Mental Health Care and Substance Use Care

The MHSU Program has two levels of benefits: Network Coverage and Non-Network Coverage.

If You choose Network Coverage

Using a Network Provider offers You the highest benefit level under The Empire Plan.

- Network Providers have been credentialed by the 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 Care or Substance Use 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 Use Program.

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

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

If Your inpatient or outpatient treatment is determined to be not Medically Necessary, You will not receive any Empire Plan benefits and You will be responsible for the full cost of care.

If You choose 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 Network Providers can charge. **If You choose or use a Non-Network Provider, prior to receiving services, it is Your responsibility to ensure that the Non-Network Provider is an Approved Facility and it obtains required Precertification.**

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

Certain Outpatient Services do not need prior Precertification (see *Schedule of Benefits for Covered Services*, page 113). 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 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 must call the Program Administrator to start the Certification process prior to receiving services, or as soon as is reasonably possible.

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

If Your Non-Network 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.

If You need Emergency Care

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

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

When You receive Medically Necessary Covered Services from a Non-Network Provider in an emergency, the Program will provide Network Coverage until You can be transferred to a Network Facility. If You choose to be transferred to a Non-Network Facility when a Network Facility is available, You will be solely responsible for any portion of the bill not covered under this Plan.

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 Program Administrator with all information and records relating to such services. At all times, the Program Administrator will treat medical records and information in the strictest confidence.

What Is Covered Under the MHSU Program

This section describes Program coverage for Inpatient and Outpatient Services.

Inpatient Services

Coverage for Inpatient Services includes the following Medically Necessary services:

A. **Hospital Services** for the treatment of Mental Health Care and Substance Use Care are covered. If the Program Administrator determines that inpatient treatment is no longer necessary, the Program Administrator will notify You, Your Physician 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 Services 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 Network Coverage if the admission is Precertified by the Program Administrator. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law, and, in other states, to Facilities that are licensed or Certified to provide the same level of treatment.

C. Mental Health Care or Substance Use Care 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 Use or Medical Inpatient in an Approved Facility.** If You are receiving inpatient Mental Health Care or Substance Use Care from a Practitioner who bills separately from the hospital or Approved Facility, You are covered for Medically Necessary services. This benefit will be paid under the Inpatient Services 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 Care and Substance Use Care, You may continue to receive Certified care from Your Practitioner during Your inpatient stay. This benefit will be paid under the Inpatient Services 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 Care visits by a Practitioner while You are on the medical unit of a hospital. This benefit will be paid under the Inpatient Services 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 Care and/or Substance Use Care at that Approved Facility. Take-home drugs are not covered under the MHSU Program.

Outpatient Services

Coverage for Outpatient Services includes the following Medically Necessary services:

A. **Emergency Care** at a hospital for treatment of Mental Health Care and/or Substance Use Care services, where You are not admitted as an inpatient following that care, is considered an outpatient service.

B. **Office Visits.** You are covered for office visits for Medically Necessary Mental Health Care and Substance Use 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 Substance Use Care program, benefits are allowed for covered family sessions. When the patient is participating in a Structured Outpatient substance use Rehabilitation Program, up to 20 family sessions (per Calendar Year) for family members of an alcoholic, alcohol abuser or substance user covered under the same Empire Plan enrollment are covered by the Program. If the patient is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are covered for up to 20 family sessions (per Calendar Year), subject to Program Administrator Certification.

E. **Substance Use 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.

G. **Ambulance Services for Mental Health Care and Substance Use 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 Care and Substance Use 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 $25 Copayment per visit applies. The Program Administrator may request documentation in order to determine if any or all visits are considered crisis intervention. **Paid-in-full benefits for these services are available under Network Coverage only.**

I. **Electroconvulsive Therapy (ECT).** Electroconvulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. On and after January 1, 2021, ECT is no longer required to 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 Care or psychiatric conditions.

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

L. **Registered Nurse Practitioner.** Services provided by a registered nurse practitioner under the direct supervision of a network psychiatrist are covered under the Plan when Medically Necessary. Registered nurse practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with New York State Education Law Article 139 Section 6902.

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

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

The Program Administrator reviews Outpatient* and Inpatient Services

After obtaining Precertification, the 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

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

The Program Administrator must continue to Certify the Medical Necessity of Your care for Your Empire Plan Mental Health Care and Substance Use Care benefits to continue.

Certification denial and appeal process: Deadlines apply

Only the 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 from the date of Your receipt of the written denial notice to request a first-level 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 Program Administrator 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 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 receives 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 124, for additional information.

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

Schedule of Benefits for Covered Services

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

The following services require Precertification from the Program Administrator:

- Intensive Outpatient Program for mental health
- Structured Outpatient Program for substance use disorder
- 23-hour bed for mental health or substance use disorder
- 72-hour bed for mental health or substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavior Analysis (ABA)
- Group home
- Halfway house
- Residential treatment center for mental health*
- Residential treatment center for substance use disorder**
- Partial hospitalization for mental health
- Partial hospitalization for substance use disorder

* Precertification is not required for covered individuals under 18 years of age at Office of Mental Health–certified network facilities located within New York State.

** Precertification is not required for Office of Addiction Services and Supports–certified network facilities located within New York State.

Mental health inpatient services for children younger than 18 at an Office of Mental Health facility does not require precertification.

Network Coverage for Mental Health Care and Substance Use Care

If You follow the requirements for Network Coverage, You are responsible for paying only the following Copayments:

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

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

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

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

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

Note: There is no Copayment for Inpatient Services. 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 Care and Substance Use Care

Prior to using any Non-Network Services, You are responsible for calling the Clinical Referral Line to obtain Mental Health and Substance Use Program Precertification for care obtained from a Non-Network Provider.

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

A. **For Practitioner Services:** After You meet The Empire Plan Combined Annual Deductible, 80 percent of Usual and Customary Rate for Covered Services or actual billed charges, whichever is less. You pay the balance of 20 percent (Coinsurance) and any charges above the Usual and Customary Rate. The covered percentage becomes 100 percent of the Usual and Customary Rate 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 $1,250 for the enrollee and $1,250 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Deductible of $1,250.

Each $1,250 deductible will be reduced to $625 per Calendar Year for employees earning less than $40,210 as of **January 1, 2022**.

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

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

Each $3,750 coinsurance maximum will be reduced to $1,875 per Calendar Year for employees earning less than $40,210 as of **January 1, 2022**.

The 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 Usual and Customary Rate for covered Practitioner services.

Maximums

Mental Health Care and Substance Use Care coverage is unlimited (no maximum) for Medically Necessary Outpatient and Inpatient Services, except that outpatient treatment sessions for family members of a substance user are covered for a maximum of 20 visits per year for all family members combined.

There is no Annual maximum for Applied Behavior Analysis (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 121.

B. Services that are not Medically Necessary as defined in the section *Meaning of Terms Used*, page 105.

C. Treatment that is not Mental Health Care or Substance Use Care as defined in the section *Meaning of Terms Used*, pages 105 and 108.

D. Services where there is no underlying behavioral health condition and 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 use.

F. Services deemed experimental or investigational. However, the 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 proven 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 Care and/or Substance Use 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 MHSU 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. Services or supplies received by an individual confined in a county, state or federal correctional facility.

P. 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, sibling or by an individual or institution not defined by the Program Administrator as a Provider.

Q. 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.

R. Conditions resulting from an act of war (declared or undeclared).

S. 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 MHSU 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.

T. 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 Usual and Customary Rate 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 Care or Substance Use 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, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the actual charge or the Usual and Customary Rate, whichever is less, for the service You receive.

If The Empire Plan is secondary to Medicare, the amount payable will be determined as denoted in the *Impact of Medicare on This Plan* section, page 119.

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

- If 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.

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, the Plan has 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 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 Mental Health Care and Substance Use Care benefits that will be payable to You first.

C. **Secondary Payor** means a plan that will determine Your Mental Health Care and Substance Use Care 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 Care and Substance Use Care expenses will be reduced by the amount available under Medicare, and the Program Administrator will consider the balance for payment, subject to Copayment, deductible and Coinsurance.**

If 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 Care and Substance Use Care expenses will be reduced by the amount available under Medicare and the Program Administrator will consider the balance for payment, subject to Copayment, deductible and Coinsurance.

   If the Provider has agreed to accept Medicare assignment, Covered Expenses will be based on the Provider's reasonable charge or the amount approved by Medicare, whichever is less. If the Provider has not agreed to accept Medicare assignment, Covered Expenses will be estimated based on a percentage of approved charges as established under federal, or, in some cases, state regulations.

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

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

E. **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.

F. **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.

G. **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 benefits 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 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 that has been Precertified, You are responsible for payment of charges at the time they are billed to You. You must file a claim with the Program Administrator for services rendered under Non-Network Coverage in order to receive reimbursement. The Program Administrator pays You the non-network covered amount for the Covered Service You obtained if it is found to be Medically Necessary. You are always required to pay the deductible, Coinsurance amounts and the amount billed to You in excess of the Non-Network covered amount. Also, You are ultimately responsible for paying Your Provider any amount not paid by the Program. However, You may assign benefits to Your Non-Network Provider and the Program will pay the Covered Expenses for Non-Network Coverage directly to Your Non-Network Provider in lieu of paying You.

How, when and where to submit claims

How

- If You use Network Coverage, Your Provider will submit a claim to the Program Administrator.
- If You use Non-Network Coverage, You must submit a claim. You may obtain a claim form by calling The Empire Plan and choosing the Mental Health and Substance Use (MHSU) Program. You may also download a claim form on NYSHIP Online (see *Contact Information*, page 151). From the NYSHIP Online homepage, select Forms, then MHSU Program. If You use Non-Network Coverage, You must meet the Combined Annual Deductible before the claims are paid.

When

If You are enrolled in Medicare, an Explanation of Medicare Benefits form **must be submitted with the completed claim form or detailed bills** to receive benefits in excess of the Medicare payment.

Claims must be submitted to either the Program Administrator or Medicare, if applicable, within 120 days after the end of the Calendar Year in which Covered Expenses were incurred. If the claim is first sent to Medicare, it must be submitted to the Program Administrator within 120 days after Medicare processes the claim.

Benefits will not be paid for claims submitted after the 120 days, regardless of whether You or a Provider submits the claim, unless meeting this deadline has not been reasonably possible (for example, due to Your illness).

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

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

Where

Send completed claim forms for Non-Network Coverage with supporting bills, receipts, and, if applicable, an Explanation of Medicare Benefits form to the Program Administrator (see *Contact Information*, page 151). If You use Network Coverage, Your Provider will submit a claim to the Program Administrator.

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

Verification of claim information

The 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 Use 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 Mental Health Care or Substance Use Care or are confined at home under the care of a Practitioner for Mental Health Care or Substance Use Care, 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 use condition on the date coverage ends on Your account, the MHSU 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 Use 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 MHSU 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 Care and/or Substance Use Care or confined at home under the care of a Practitioner for Mental Health Care and/or Substance Use 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 MHSU 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 could 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 MHSU 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 MHSU 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 MHSU 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 MHSU Program provided benefits.

The MHSU Program requests that You notify it 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 MHSU 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 the Program Administrator has all the information necessary to make a determination regarding a Precertification, the Program Administrator 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 the Program Administrator needs additional information, it will request it within three business days. You or Your Provider will then have 45 calendar days from the date of request to submit the information. The Program Administrator 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 the Program Administrator's receipt of the information or the end of the 45-day time period.

With respect to Precertification of urgent claims, if the Program Administrator has all information necessary to make a determination, it 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 the Program Administrator needs additional information, it will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. The Program Administrator will make a determination and provide notice to You and Your Provider, by telephone and in writing, within 48 hours of the earlier of the 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 the Program Administrator needs additional information, it will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. The Program Administrator 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 receipt of the information or the end of the 45-day time period.

For Concurrent Reviews that involve urgent matters, the Program Administrator 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 time frames specified previously for Precertification of urgent claims.

If the Program Administrator has already approved a Course of Treatment, it will not reduce or terminate the approved services unless it has 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 the Program Administrator has all information necessary to make a determination regarding a retrospective claim, it 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 the Program Administrator needs additional information, it will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to submit the information. The Program Administrator will make a determination and provide notice to You and Your Provider within 15 calendar days of the earlier of receipt of the information or the end of the 45-day time period. If the Program Administrator has all information necessary to make a decision but fails to make a determination within the required time frames, this will be deemed an adverse determination, subject to an internal appeal. If upon internal appeal, the Program Administrator does not make a decision within the required time frames, the adverse determination will be reversed.

Notice of adverse determination

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 the Program Administrator's determination, date of service, Provider name and claim amount (if applicable). The notice will also advise You of Your right to appeal the 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 the Program Administrator to review an appeal. The notice will also refer to the Plan provision on which the denial is based. The Program Administrator will send notices of determination to You (or Your designee) and, as appropriate, to Your health care Provider. If the Program Administrator provides a notice of adverse determination but does not attempt to consult with Your Provider who recommended the service, Your Provider may request a reconsideration of the adverse determination.

Appeals

Appeals: 180-day deadline

In the event a Certification or claim has been denied, in whole or in part, You may request a review. This request for review must be sent to the Program Administrator appeals department (see *Contact Information*, page 151) within 180 days after You receive a notice of denial of the Certification or claim.

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.

Appeals involving urgent situations

If an Appeal involves a situation that could seriously jeopardize Your life or health or Your ability to regain maximum function, based on a prudent layperson's judgment or the opinion of a Provider with knowledge of Your medical condition, and would subject You to severe pain that cannot be adequately managed without the care of the requested treatment, then the Appeal will be resolved in no more than 72 hours from receipt of the Appeal. Notice of the determination will be made directly to the person filing the Appeal (You or the person acting on Your behalf).

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

Please refer to *Certification denial and appeal process: Deadlines apply*, page 112, 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 153).

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

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 lowercase 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 a Dispense as Written Exception Request 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. **Dispense as Written (DAW) Exception Request** is a process by which a physician submits a request to the Program showing that it is medically necessary for You to have a non-preferred Brand-Name Drug (that has a generic equivalent). If approved, You would pay the non-preferred Copayment, but You will not have to pay the Ancillary Charge.

E. **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 in a method specified in a Prescription issued by a medical professional. The 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 Drug(s)/Medication(s) by this Program.

F. **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.

G. **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.

H. **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 they are acting within the scope of their license.

I. **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.

J. **Excluded Drug** is a drug that is excluded from coverage under this Program's benefit and/or 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 Program* for information on how to Appeal an Excluded Drug.

K. **Formulary.** In a Formulary, including an Advanced Flexible or 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 Program Request** 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 134.

R. **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.

S. **Non-Preferred Drug** means a Brand-Name Drug that is not subject to a Level 1 or Level 2 copayment on the Empire Plan Advanced Flexible Formulary drug list.

T. **Pharmacist** means a person who is legally licensed to practice the profession of Pharmacy. They must regularly practice such profession in a Pharmacy.

U. **Pharmacy** means an establishment that is registered as a Pharmacy with the appropriate state licensing agency or is a U.S. Department of 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 134, must be regularly dispensed from the Pharmacy by a Pharmacist.

V. **Preferred Drug** means a Brand-Name Drug that is subject to a Level 1 or Level 2 copayment on the Empire Plan Advanced Flexible Formulary drug list.

W. **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 their professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

X. **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.

Y. **Program** means the Empire Plan Prescription Drug Program described in this *Certificate*.

Z. **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.

AA. **Therapeutic Category** means categories by which drugs are identified and grouped by the main conditions they treat.

AB. **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.

AC. **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.

AD. **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.

AE. **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
- **$30** for **Preferred** Drugs, Compound Drugs or Level 2 Drugs
- **$60** for **Non-Preferred** Drugs, certain **Generic** Drugs or Level 3 Drugs

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

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

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

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

Note: Oral chemotherapy drugs for the treatment of cancer do not require a copayment. Per New York State law, the Plan covers at least one product under each of the FDA's contraceptive categories at a $0 copayment. Information on preventive medications that are available without cost sharing is available in *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 150).

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.

Effective April 1, 2021, erectile dysfunction drugs, which can also be used for benign prostatic hyperplasia, are limited to 30 units for a 30-day supply and 90 units for a 90-day supply. All other erectile dysfunction drugs are limited to six units every 30 days and 18 units every 90 days.

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 (QL) limits, additional quantities may be covered through prior authorization (PA). These drugs will be noted with QL/PA on the formulary. Please see *Prior authorization required for certain drugs*, page 133, for information on how to request a prior authorization.

You may have a 12-month supply of a contraceptive drug or device dispensed to You.

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.

Dispense as Written Exception Requests

If Your Doctor believes it is medically necessary for You to have a non-preferred Brand-Name Drug (that has a generic equivalent), You may submit a DAW Exception Request. To begin the DAW Exception Request process, Your Doctor should submit a DAW Exception Request or call The Empire Plan and choose the Prescription Drug Program.

If Your DAW Exception Request is granted and You fill Your Prescription for a non-preferred Brand-Name Drug at a Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy, You pay the non-preferred copayment. You will not have to pay the Ancillary Charge. If Your DAW Exception Request is denied, You may Appeal to the Program Administrator.

Act promptly. If Your Appeal is approved, the pharmacy will either reverse and reprocess the claim, or the pharmacy will work with CVS Caremark to allow a new claim to be processed with the approved exception so that the ancillary charge is not applied.

Empire Plan Advanced Flexible Formulary

Under the Empire Plan Advanced Flexible Formulary plan design, drugs are classified by Therapeutic Category or medical condition 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 works in a certain way. For example, antibiotics are used for the treatment of infections. See *Contact Information*, page 152, for details.

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

Please refer to the *Exclusions and Limitations* section, page 135, for information about where You can find a list of drugs not covered by the Empire Plan Prescription Drug Program.

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.

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 go to NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Using Your Benefits and then Prior Authorization Drug List.

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 NYSHIP Online (from the NYSHIP Online homepage, select Using Your Benefits and then Specialty Pharmacy Drug List) or call the Empire Plan Prescription Drug Program (see *Contact Information*, page 149).

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). Compound Drugs that have a claim cost to the Program that exceeds $200 will require prior authorization under this Program.

D. Injectable insulin.

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

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

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

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

I. 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.

J. Claims for drugs dispensed outside of the United States that have an available U.S. FDA-approved equivalent.

K. Orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.

L. Off-label cancer drugs.

M. 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.

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

O. Bowel preparation products for colorectal cancer screenings that are FDA-approved Prescription drugs and bear the legend "Rx Only" or are recommended for preventive services under the Patient Protection and Affordable Care Act (PPACA). PPACA preventive services recommendations can be found at www.uspreventiveservicestaskforce.org.

P. Certain prescription and over-the-counter medications that are recommended for preventive services without cost sharing and have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). **Note:** When available over-the-counter, USPSTF "A" and "B" rated medications require a prescription order to process without cost sharing.

Q. Pre-Exposure Prophylaxis (PrEP), when prescribed for enrollees who are at high risk of acquiring HIV.

* Shingrix® is paid in full for enrollees and dependents age 50 and older.

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 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), with the exception of certain diabetic supplies, 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 145. 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 their 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 142.

O. Any drug prescribed and/or dispensed in violation of state or federal law.

P. Prescription drug products excluded from the benefit plan design.

Q. New Prescription drug products that are in the same Therapeutic Category as existing drugs excluded under the Empire Plan Advanced Flexible Formulary or that are in the same Therapeutic Category as drugs excluded from benefit coverage under this Plan. Please go to NYSHIP Online or call the Empire Plan Prescription Drug Program (see *Contact Information*, page 149) 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.

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 U.S. Food and Drug Administration.

Important: Refer to *Home Care Advocacy Program (HCAP)* in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, page 70, for coverage for Prescription drugs billed by a home care agency.

Note: For a current list of Excluded Drugs, go to NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Using Your Benefits and then click on the Excluded Drug List.

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 up to 90 days. Refills of covered drugs are provided for up to a year from the date when 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 N. in *What is covered*, page 135) 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 go to the website (see *Contact Information*, page 152).

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 152).

Mail the completed form with Your bills or receipts to the Empire Plan Prescription Drug Program (see *Contact Information*, page 152).

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 must request that Your Doctor send Your prescription to the Mail Service Pharmacy and then You will 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 149). The Mail Service Pharmacy or the Designated Specialty Pharmacy address is also listed here.

Using the Empire Plan Advanced 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 Advanced Flexible Formulary drug list. The Empire Plan Advanced Flexible Formulary drug list is available on NYSHIP Online (see *Contact Information*, page 149). From the NYSHIP Online homepage, select Using Your Benefits and then Empire Plan Advanced Flexible Formulary. This is not a complete list of all Prescription drugs on the Advanced 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 Advanced 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 Advanced 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 Program for drugs excluded from the Advanced Flexible Formulary (for Empire Plan-primary enrollees)*, page 143.

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 Advanced 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:

- Regulations regarding age limits may differ by state.
- New York State restricts Pharmacists from administering vaccines to anyone younger than 18, with the exception of the influenza vaccine. The influenza vaccine may be administered by Pharmacists for persons two years of age and older.
- The no-copayment benefit for Shingrix® applies to enrollees and dependents age 50 and older.
- 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 press or say 4 for 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

Go to NYSHIP Online. From the NYSHIP Online homepage, select 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 or check order status
- Download a Mail Service Pharmacy order form
- View the list of drugs subject to prior authorization
- View the Advanced 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 (the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year.
   - If 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.
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, the Plan has 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

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

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 will also be canceled for Hospital, Medical/Surgical and Mental Health and Substance Use benefits.

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

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 their 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 could 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 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 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 Program for drugs excluded from the Advanced Flexible Formulary (for Empire Plan-primary enrollees)

The Empire Plan includes a Medical Exception Program for non-formulary Prescription drugs that are excluded from coverage. Enrollees and their physicians must first evaluate whether covered drugs on the Advanced 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 Medical Exception Request (see *Contact Information*, page 152, for details). If the Medical Exception is approved, the Level 1 copayment will apply for Generic Drugs and the Level 3 copayment will apply for Brand-Name Drugs.

Note: Drugs that are only approved by the U.S. Food and Drug Administration (FDA) 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 152).

Call The Empire Plan and choose the Prescription Drug Program to learn about the appeals process.

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 152) 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 time frames 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 time frames 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 153).

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 153). 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. However, they can 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 You may be using Prescription drugs in a harmful or abusive manner or with harmful frequency, the Plan reserves the right to limit You 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 You.

Upon processing of an incoming claim, Your Prescription drug claim history is reviewed by the systematic RTS criteria. The RTS edit will cause the claim to reject if You should have consumed (based on days' supply) less than 75 percent of Your medication on a cumulative basis. When a claim is rejected, the Pharmacist is sent a message that indicates Your next refill date. Certain drugs that have quantity-level limits, such as erectile dysfunction drugs, have more restrictive RTS limits to comply with the quantity allowed per days' supply. See *Supply and coverage limits*, page 132, for additional information.

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, go to NYSHIP Online at www.cs.ny.gov/employee-benefits. Select NY and then UUP and Empire Plan Enrollee, if prompted, to access the NYSHIP Online homepage.

The Empire Plan

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program.

Medical/Surgical Program

Administered by UnitedHealthcare

Choose this option for medical/surgical benefits; most claims and appeals; outpatient radiology; certification of home care; medical equipment and supplies; Centers of Excellence for Infertility and Cancer; chiropractic, physical therapy or occupational 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

www.myuhc.com

Claims submission fax: 845-336-7716

Claims submission online: https://nyrmo.optummessenger.com/public/opensubmit

External appeals

New York State Department of Financial Services
1-800-400-8882

P.O. Box 7209
Albany, NY 12224-0209

Fax: 1-800-332-2729

Email: externalappealquestions@dfs.ny.gov

Home Care Advocacy Program (HCAP) appeals

UnitedHealthcare
Empire Plan/Home Care Advocacy Program/HCAP Appeals
P.O. Box 1600
Kingston, NY 12402

Fax: 1-877-742-1403

Managed Physical Medicine Program appeals
Administered by Managed Physical Network, Inc. (MPN)
Managed Physical Network, Inc.
P.O. Box 8200
Kingston, NY 12402-8200

Fax: 845-382-1341

Diabetic supplies (except insulin pumps and Medijectors)
Empire Plan Diabetic Supplies Pharmacy
1-800-321-0591

Ostomy supplies
Byram Healthcare Centers
1-800-354-4054

PRESS OR SAY 2 **Hospital Program**
Administered by Empire BlueCross
(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
New York State Service Center
P.O. Box 1407, Church Street Station
New York, NY 10008-1407

www.empireblue.com

Claims submission fax: 1-888-367-9788

Other claims
If the hospital does not deal directly with its local Blue Cross Plan:
When filing the claim directly with the local Blue Cross Plan, refer the bill to:
Code YLS, Empire BlueCross
New York State Service Center
P.O. Box 1407, Church Street Station
New York, NY 10008-1407

Hospitals outside of the United States:
BlueCross BlueShield Global Core
P.O. Box 2048
Southeastern, PA 19399

Written appeals

Empire BlueCross
Empire Plan Appeals Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

External appeals

New York State Department of Financial Services
1-800-400-8882

P.O. Box 7209
Albany NY, 12224-0209

Fax: 1-800-332-2729

Email: externalappealquestions@dfs.ny.gov

PRESS OR SAY 3 Mental Health and Substance Use Program

Administered by Beacon Health Options

Choose this option for mental health and substance use 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 1850
Hicksville, NY 11802

www.achievesolutions.net/empireplan

Claims submission fax: 855-378-8309

Claims submission forms can be submitted via the MemberConnect portal:
www.beaconhealthoptions.com/members/beacon/

Written appeals

Beacon Health Options Appeals Department
P.O. Box 1851
Hicksville, NY 11802

External appeals

New York State Department of Financial Services
1-800-400-8882

P.O. Box 7209
Albany, NY 12224-0209

Fax: 1-800-332-2729

Email: externalappealquestions@dfs.ny.gov

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

www.empireplanrxprogram.com

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:
The Empire Plan Prescription Drug Program
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Online:
Log on to Caremark.com and choose Submit a Claim under Plan & Benefits.

Medical Exception Requests for drugs excluded from the Advanced Flexible Formulary

Tell Your physician to fax these Requests to 1-888-487-9257.

Dispense as Written Exception Requests for non-preferred Brand-Name Drugs on the Advanced Flexible Formulary

Request forms are available on NYSHIP Online or at www.caremark.com/portal/asset/NYSHIP_DAW_Exception_Request_Form.pdf.

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

P.O. Box 7209
Albany, NY 12224-0209

Fax: 1-800-332-2729

Email: externalappealquestions@dfs.ny.gov

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**:
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

www.dfs.ny.gov

If You need assistance filing a grievance or appeal, You may also contact:

State Independent Consumer Assistance Program
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

1-888-614-5400

www.communityhealthadvocates.org

Email: cha@cssny.org

NYSHIP HMOs

NYSHIP HMO contact information, including phone numbers, TTY numbers, addresses and websites are available in the *Choices* booklet and at www.cs.ny.gov/employee-benefits. Select NY and then UUP and HMO Enrollee, if prompted. From the NYSHIP Online homepage, select Using Your Benefits and then Telephone Numbers.

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, Amyotrophic Lateral Sclerosis (also known as Lou Gehrig's disease) 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

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

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