NYSHIP
New York State Health Insurance Program

# General Information Book & Empire Plan Certificate Amendments

For Contract Affected Employees
of the State of New York in **Council 82**
and for their enrolled Dependents
*and for COBRA enrollees with their benefits*

**October 2007**

State of New York Department of Civil Service
Employee Benefits Division
www.cs.state.ny.us

**Keep these amendments with your July 1, 2003 *New York State Health Insurance Program General Information Book and Empire Plan Certificate for Employees of the State of New York represented by Council 82.*** Pages in your Book/Certificate and later Certificate Amendments have consecutive numbers.

## New York State Health Insurance Program General Information Book



## Empire Plan Certificate Amendments

### Benefits Management Program



### Empire BlueCross BlueShield



### UnitedHealthcare



*Continued on inside front cover*

*Continued from front cover*

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

Where this document differs from your July 1, 2003 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports* and *Certificate Amendments,* this is the controlling document.

## NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

*Substitute the following for the third sentence of the first paragraph of "Or your domestic partner" under "Your dependents" in the "Who is Eligible?" section on page 4 of your NYSHIP General Information Book.*

**Domestic partner**

**Effective October 1, 2007.** To enroll a domestic partner, you must have been in the partnership for six months and be able to provide proof of residency and financial interdependence.

*Substitute the following for the fifth paragraph of "Or your domestic partner" under "Your dependents" in the "Who is Eligible?" section on page 5 of your NYSHIP General Information Book.*

**Effective October 1, 2007.** There will be a one-year waiting period from the termination date of your previous partner's coverage before you may again enroll a domestic partner.

*Substitute "Empire Plan Benefit Card" wherever "New York Government Employee Benefit Card" appears in your NYSHIP General Information Book and Empire Plan Certificate.*

*Substitute the following for the first paragraph, "Your card" and the second paragraph "Separate card for each dependent" under "Identification Cards" on page 11 of your NYSHIP General Information Book.*

**Identification card**

Your Empire Plan Benefit Card is a plastic card similar to a bank or credit card. You will receive your Empire Plan Benefit Card after your enrollment in The Empire Plan is processed.

*Substitute the following for the bordered section, "Sample New York Government Employee Benefit Card for Empire Plan Enrollees"on page 12 of your NYSHIP General Information Book.*

### Sample Empire Plan Benefit Card for Empire Plan Enrollees

**The nine digits are your alternate Identification Number.**

**The BlueCross BlueShield Inter-Plan Bank Code is YLS.** Out-of-State hospital claims submitted with this code will reach the correct BlueCross and/or BlueShield plan.


*Substitute the following for "If you do not follow the pre-admission certification requirements" on pages 44-45 of The Empire Plan Benefits Management Program.*

**Pre-admission certification**

**Effective October 1, 2007. If you do not follow the pre-admission certification requirements:**

If you did not call the Benefits Management Program for pre-admission certification of an elective (scheduled) inpatient admission or an admission for the birth of a child,

or

if you did not call the Benefits Management Program within 48 hours after an emergency or urgent admission,

or

if you followed the procedures for emergency or urgent admissions when you should have followed the pre-admission certification procedures for an elective (scheduled) admission or an admission for the birth of a child, you will be required to pay:

- a $200 hospital deductible if it is determined that any portion of your hospitalization was medically necessary

and

- **Effective October 1, 2007,** you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

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

If you call the Benefits Management Program and if 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.

*Substitute the following for the last sentence of the first paragraph and the first two bulleted paragraphs of "There are penalties for not complying with the Prospective Procedure Review requirements" in the "Prospective Procedure Review: MRI" section on pages 46-47 of The Empire Plan Benefits Management Program.*

**Prospective procedure review: MRI**

**Effective October 1, 2007.** If you fail to call and the Empire BlueCross BlueShield and/or UnitedHealthcare review confirms that the MRI was medically necessary but not an emergency, you will be responsible for paying the following:

- When the MRI 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 MRI is an Empire Plan participating provider under the Medical 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 $18 copayment.

# EMPIRE BLUECROSS BLUESHIELD CERTIFICATE OF INSURANCE

*Insert the following under "2." of "Introduction" on page 50 of your Empire BlueCross BlueShield Certificate.*

**Network and non-network facilities**

**Effective October 1, 2007. Network hospitals and facilities** means hospitals and facilities that participate in the BlueCross and BlueShield Association Blue Card PPO® Program through local BlueCross and/or BlueShield plans. When you use network hospitals and facilities, covered services are paid in full subject to the Benefits Management Program requirements and except for any applicable copayments that you pay.

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

*Substitute the following for "If you do not follow the provisions of the Benefits Management Program" under "Hospital admission" in the "Benefits Management Program" section on page 51 of your Empire BlueCross BlueShield Certificate.*

**Hospital admission**

**Effective October 1, 2007. If you do not follow the provisions of the Benefits Management Program,** Empire BlueCross BlueShield will still review your claim and will apply the following deductibles and copayments:

- If you did not call the Benefits Management Program for Pre-Admission Certification of an elective (scheduled) inpatient admission or an admission for the birth of a child, Empire BlueCross BlueShield will apply a $200 hospital deductible. Effective October 1, 2007, no payment will be made for any day during which it was not medically necessary for you to be an inpatient.
- If you called the Benefits Management Program and did not receive certification for your admission and you are admitted to the hospital as an inpatient, you will be responsible for all charges for each day it was not medically necessary for you to be an inpatient. If only a part of your inpatient stay was certified, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.
- If you did not call the Benefits Management Program within 48 hours after an emergency or urgent hospital admission, Empire BlueCross BlueShield will apply a $200 hospital deductible. In addition, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

  You may appeal the penalty imposed for failure to call within 48 hours, if you did not call within the required 48 hours after an emergency or urgent hospital admission due to circumstances beyond your control (for example, due to your illness), but did call as soon as was reasonably possible.
- If it is determined that you followed the procedures for emergency or urgent admission when you should have followed the Pre-Admission Certification procedures for an elective (scheduled) admission or admission for the birth of a child, Empire BlueCross BlueShield will apply a $200 hospital deductible. In addition, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

*Substitute the following for the last two sentences of "Outpatient MRI" in the "Benefits Management Program" section on page 52 of your Empire BlueCross BlueShield Certificate.*

**Outpatient MRI**

**Effective October 1, 2007.** If you fail to call the Benefits Management Program and Empire BlueCross BlueShield'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.

*Insert the following before "Inpatient Hospital Care" on page 52 of your Empire BlueCross BlueShield Certificate.*

## Network and Non-Network Benefits

**Network and non-network benefits**

**Effective October 1, 2007.** 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.

1. Network benefits: When you use a network hospital, skilled nursing facility or hospice care facility, inpatient and outpatient covered services are paid in full except for:
   A. any applicable hospital outpatient copayments; and
   B. any hospital deductibles or coinsurance amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.
2. Non-network benefits: When you use a non-network hospital, skilled nursing facility or hospice care facility, you are responsible for a larger share of the cost of covered services, unless the criteria listed in section 3, below, apply. You are responsible for:
   A. 10 percent of the billed charges for inpatient hospital, skilled nursing facility or hospice care facility services up to the coinsurance maximum;
   B. 10 percent of the billed charges or a $75 copayment for hospital outpatient services, whichever is greater, up to the coinsurance maximum.

   The **annual coinsurance maximum** for covered inpatient/outpatient services received at a non-network hospital and covered inpatient services received at a non-network skilled nursing facility or hospice care facility is $1,500 for the enrollee, $1,500 for the enrolled spouse/domestic partner, and $1,500 for all dependent children combined. After the maximum levels have been reached, inpatient services are paid in full, hospital emergency room visits are subject to a $60 copayment, hospital outpatient services are subject to a $35 copayment and physical therapy services are subject to an $18 copayment. Once you have paid $500 in non-network coinsurance, amounts in excess of $500 are reimbursable under the Basic Medical Program (see page 174 of these Empire Plan Amendments).

   Non-network coinsurance and copayment amounts apply in addition to any deductible and coinsurance amounts that are your responsibility because of your failure to meet the requirements of the Benefits Management Program.
3. 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 by Empire BlueCross BlueShield as an emergency or urgent inpatient or outpatient admission;
D. When care is received outside the United States;
E. When another insurer, including Medicare is providing primary coverage.

The Empire Plan BlueCross BlueShield 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 deductibles or coinsurance amounts that apply because of your failure to follow the requirements of the Benefits Management Program. You are responsible for making the payment to the non-network hospital.

Empire Plan network hospitals, hospices and skilled nursing facilities are listed on the New York State Department of Civil Service web site at www.cs.state.ny.us. Click on Benefit Programs, then on NYSHIP Online. Select your group and then click on Find a Provider. You can also call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire BlueCross BlueShield.

*Substitute the following for the first sentence of "2. Hospital services covered." in the "Inpatient Hospital Care" section on page 52 of your Empire BlueCross BlueShield Certificate.*

**Inpatient hospital care**

**Effective October 1, 2007.** Empire BlueCross BlueShield will usually pay, subject to network and non-network benefit levels, for all the diagnostic and therapeutic services provided by the hospital.

*Substitute the following for the thirteenth bullet, "Chemotherapy" under "2. Hospital services covered." in the "Inpatient Hospital Care" section on page 52 of the Empire BlueCross BlueShield Certificate.*

- Chemotherapy except if you are enrolled in the UnitedHealthcare Centers of Excellence Program and receiving care at a Cancer Resource Services network facility.

*Substitute the following for the first paragraph of the "Outpatient Hospital Care" section on page 53 of your Empire BlueCross BlueShield Certificate as amended in your January 2004 Empire Plan Report.*

**Outpatient hospital care**

**Effective October 1, 2007.** When you receive the services described in the following sections and subject to the limitations in those sections, Empire BlueCross BlueShield will pay for the same services provided to you in the outpatient department of a hospital as Empire BlueCross BlueShield pays when you are an inpatient in a hospital as described on page 52 under *"Inpatient Hospital Care."* This coverage also applies to services provided at a hospital extension clinic (a remote location including ambulatory surgical centers) owned and operated by the hospital. As in the case of inpatient care, the service must be given by an employee or an agent of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service.

*Substitute the following for the second paragraph under "5. Physical therapy." in the "Outpatient Hospital Care" section on page 54 of your Empire BlueCross BlueShield Certificate.*

**Physical therapy**

**Effective October 1, 2007.** You pay an $18 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 Empire BlueCross BlueShield. This payment is in addition to any other payment, either copayment or coinsurance, applied to outpatient services rendered on the same day.

*Substitute the following for the first sentence of "7. Chemotherapy." in the "Outpatient Hospital Care" section on page 54 of your Empire BlueCross BlueShield Certificate.*

**Chemotherapy**

7. **Chemotherapy**. Empire BlueCross BlueShield pays for chemotherapy, except if you are enrolled in the UnitedHealthcare Centers of Excellence Program and receiving care at a Cancer Resource Services network facility.

*Substitute the following for "$35 copayment for emergency care" in the "Outpatient Hospital Care" section on page 54 of your Empire BlueCross BlueShield Certificate.*

**Copayment for emergency care**

**Effective October 1, 2007.** You must pay the first $60 in charges (copayment) for emergency care in a hospital emergency room. See *page 53, "Outpatient Hospital Care,"* for emergency care. Hospitals may require payment of this charge at the time of service.

The $60 emergency room copayment covers use of the facility for **emergency care** *and* services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services. Refer to your UnitedHealthcare Certificate, *page 83, "What is Covered Under the Basic Medical Program (non-participating providers),"* if you receive bills for hospital emergency room service from these providers.

You will not have to pay this $60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

*Substitute the following for "$25 copayment for outpatient hospital services" in the "Outpatient Hospital Care" section on page 55 of your Empire BlueCross BlueShield Certificate.*

**Copayment for outpatient hospital services**

**Effective October 1, 2007.** You must pay the first $35 in charges (copayment) for each visit to a network facility or the greater of 10 percent of charges or $75 at a non-network facility where you receive one or more of the following covered hospital outpatient services, and hospitals may require payment of this charge at the time of service:

- Surgery
- Diagnostic radiology, including mammography according to above guidelines
- Diagnostic laboratory tests
- Administration of Desferal for treatment of Cooley's Anemia

**Only one** copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The $35 copayment covers the outpatient facility.

You will not have to pay this $35 facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you at that time as an inpatient.

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

- Pre-admission testing and/or pre-surgical testing prior to inpatient admission
- Chemotherapy
- Radiation therapy
- Dialysis

When the above services are provided at a non-network facility, you must pay the greater of 10 percent of charges or $75.

*Substitute the following for "A." and "B." under "2. Kind of skilled nursing facility." in the "Skilled Nursing Facility Care" section on page 55 of your Empire BlueCross BlueShield Certificate.*

**Skilled nursing facility**

2. **Covered skilled nursing facilities.** Benefits for covered services are provided if the facility is either:

A. a facility that is accredited as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations; or

B. certified as a participating skilled nursing facility under Medicare.

**Effective October 1, 2007,** coverage is subject to the network and non-network level of benefits.

*Substitute the following for "1. Hospice organizations." in the "Hospice Care" section on page 56 of your Empire BlueCross BlueShield Certificate.*

**Hospice care**

1. **Hospice organizations.** Empire BlueCross BlueShield 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.

**Effective October 1, 2007,** coverage is subject to the network and non-network level of benefits.

*Substitute the following for the second paragraph of "Infertility Benefits" and for "Maximum lifetime benefit" in the "Infertility Benefits" section on page 57 of your Empire BlueCross BlueShield Certificate.*

**Infertility benefits**

**Effective October 1, 2007.** Infertility benefits, including Qualified Procedures (see below), 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.

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

## UNITED HEALTHCARE CERTIFICATE OF INSURANCE

*Substitute the following for "Note" in the "Plan Overview" section on page 74 of your UnitedHealthcare Certificate.*

**Plan overview**

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

**$18 copayment**

**Effective October 1, 2007.** *Substitute "$18 copayment" for "$10 copayment" wherever the $10 appears in your UnitedHealthcare Certificate.*

*Substitute the following for "Hospital admission" on page 75 of your UnitedHealthcare Certificate.*

**Hospital admission**

**Effective October 1, 2007.** If you have a hospital admission which is covered under this Plan, you must comply with the **Pre-Admission Certification** requirements. If you do not comply, you will be subject to paying a $200 inpatient deductible if any portion of the hospitalization is determined to be medically necessary. **Effective October 1, 2007,** you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

*Substitute the following for the third paragraph of "T. 2. b." of "Meaning of Terms Used" on page 79 of your UnitedHealthcare Certificate.*

**Coinsurance maximum**

However, the annual deductible does not count toward the coinsurance maximum. Any expenses above the reasonable and customary charge do not count. Your expenses under the Managed Physical Medicine Program, Mental Health and Substance Abuse Program and Empire BlueCross BlueShield Hospital Program do not count, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program. Any reimbursement for non-network hospital out-of-pocket expenses does not count.

*Substitute the following for "U. Outpatient" in the "Meaning of Terms Used" section on page 79 of your UnitedHealthcare Certificate.*

**Outpatient**

U. **Effective October 1, 2007. Outpatient** means that covered medical expenses are incurred in a doctor's office, in the outpatient department of a hospital or in a hospital extension clinic (a hospital owned and operated remote location including an ambulatory facility).

*Substitute the following for the third sentence of "Infertility Benefits requirements apply..." on page 76 and the second sentence of "X. The Lifetime Maximum" under "Meaning of Terms Used" on page 79 of your UnitedHealthcare Certificate.*

**Infertility benefits maximum**

**Effective October 1, 2007.** The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is $50,000 per covered person under The Empire Plan hospital and medical programs.

*Add the following at the end of "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 82 of your UnitedHealthcare Certificate as amended in your September 2005 Amendments.*

**Prostheses and orthotic devices**

U. **Effective October 1, 2007. Prostheses and Orthotic Devices** – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs. Replacements, when functionally necessary, are also covered. There is no copayment for the prosthesis and/or orthotic device when you use a participating provider. Mastectomy bras obtained from participating providers are covered in accordance with this benefit.

*Add the following after the third paragraph in the "Basic Medical Program" section on page 83 of your UnitedHealthcare Certificate.*

**Basic Medical Provider Discount Program**

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

- The Empire Plan is your primary coverage;
- you receive covered Basic Medical services from the non-participating provider;
- the discounted fee is lower than the Basic Medical reasonable and customary allowance; and

- you have met your annual Basic Medical deductible.

You will not be billed for charges in excess of the discounted fee. The provider will submit claims for you and UnitedHealthcare will pay the provider directly.

*Substitute the following for "Assignment of benefits..." in the "Basic Medical Program" section on page 83 of your UnitedHealthcare Certificate.*

**Assignment of benefits**

**Assignment of benefits to a non-participating provider is not permitted.** (Assignments will be made to hospitals and for ambulance services as long as the ambulance service has a contract in effect with UnitedHealthcare and to providers in The Empire Plan Basic Medical Provider Discount Program.)

*Substitute the following for the last paragraph of "A. Hospitals" under "What is covered ..." in the "Basic Medical Program" section on page 84 of your UnitedHealthcare Certificate.*

**Coverage**

UnitedHealthcare 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's hospital benefits plan.

*Add the following after "A. Hospitals" under "What is covered ..." in the "Basic Medical Program" section on page 84 of your UnitedHealthcare Certificate. (Adjust the letters that follow.)*

**Non-network Hospital Program expenses**

B. **Effective October 1, 2007. Non-network Hospital, Skilled Nursing Facility and Hospice Care Facility Out-of-Pocket Expenses** – If The Empire Plan provides your primary coverage and you incur out-of-pocket expenses under the Hospital Program as the result of using a non-network hospital, skilled nursing facility or hospice care facility for covered services, you may submit a claim to UnitedHealthcare for reimbursement of any such expenses over $500 up to the combined $1,500 non-network hospital, skilled nursing facility or hospice care facility coinsurance maximum. This reimbursement is not subject to the Basic Medical deductible or coinsurance. **Any hospital deductibles or coinsurance amounts applied because you failed to meet the requirements of the Benefits Management Program are not reimbursable nor do they count toward the $500 threshold for reimbursement.** You must provide UnitedHealthcare with a copy of your Empire BlueCross BlueShield explanation of benefits to document the amount of your covered out-of-pocket expense.

**Radiology, anesthesiology, pathology**

C. **Effective October 1, 2007. Radiology, Anesthesiology and Pathology** – If you receive anesthesia, radiology or pathology services in connection with 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 UnitedHealthcare.

*Substitute the following for "O. Prosthetics" under "What is covered ..." in the "Basic Medical Program" section on page 85 of your UnitedHealthcare Certificate.*

**Prostheses and orthotic devices**

Q. **Effective October 1, 2007. Prostheses and Orthotic Devices** – One prosthesis and/or orthotic device per affected body part meeting an individual's functional needs is covered. Replacements when functionally necessary are also covered.

*Substitute the following for "R. Hearing Aids" under "What is covered..." in the "Basic Medical Program" section on page 85 of your UnitedHealthcare Certificate.*

**Hearing aids**

T. **Hearing Aids — Effective January 1, 2007.** Hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of $1,500 per hearing aid per ear, once every four years. Children age 12 years and under 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.*

*Add the following at the end of "What is covered..." in the "Basic Medical Program" section on page 86 of your UnitedHealthcare Certificate.*

**Mastectomy prostheses**

AB. **Effective October 1, 2007. 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 approval through the Home Care Advocacy Program (HCAP). Call HCAP toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose UnitedHealthcare before you purchase the prosthesis. For a prosthesis requiring approval, if a less expensive prosthesis can meet an individual's functional needs, benefits will be available for the most cost-effective choice. *This benefit is not subject to deductible or coinsurance.*

*Substitute the following for "Pre-Admission Certification: Hospital" in the "Benefits Management Program" section on page 86 of your UnitedHealthcare Certificate.*

**Hospital admission**

**Effective October 1, 2007.** If you do not comply with Pre-Admission Certification requirements for hospital admission, you will be subject to paying a $200 hospital deductible. No payment will be made for any day it is determined that your hospitalization is not medically necessary.

*Substitute the following for the second paragraph of "A. Durable Medical Equipment" under "HCAP-covered Durable Medical Equipment and Supplies" in the "Home Care Advocacy Program" section on page 88 of your UnitedHealthcare Certificate.*

**HCAP**

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

*Substitute the following for the second paragraph of "Infertility Benefits" on page 92 of your UnitedHealthcare Certificate.*

**Infertility benefits**

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. Effective October 1, 2007, Qualified Procedures are subject to a $50,000 lifetime maximum.

*Substitute the following for "Maximum lifetime benefit" in the "Infertility Benefits" section on page 93 of your UnitedHealthcare Certificate.*

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

*Substitute the following for the second paragraph under "Infertility Centers of Excellence" in the "Infertility Benefits" section on page 93 of your UnitedHealthcare Certificate.*

**Infertility Centers of Excellence**

When attending an Infertility Center of Excellence for Qualified Procedures more than 100 miles from a patient's residence, benefits are also available for travel, lodging and meal expenses. Reasonable expenses for the patient and one family member companion traveling on the same day to and/or from the center are payable under this infertility benefit. Travel by private automobile will be

reimbursed at the Internal Revenue Service per-mile rate in force at the time. Available coach airfare is covered only when the authorized Infertility Center of Excellence is more than 200 miles from a patient's residence. These benefits are available only if the expenses have been pre-authorized by UnitedHealthcare and are applied toward the $50,000 maximum lifetime benefit.

*Add the following after "Infertility Benefits" on page 94 of your UnitedHealthcare Certificate.*

## Centers of Excellence for Cancer Program

**Cancer Program**

**Effective August 1, 2007.** The Centers 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 Centers of Excellence for Cancer 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 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 Centers of Excellence for Cancer Program is voluntary, but the enhanced benefits under the Program are available only when you have enrolled with the Cancer Resource Services and notified your case manager before obtaining services.

**Centers of Excellence.** Facilities covered under the Centers 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 toll-free number, 1-877-7-NYSHIP (1-877-769-7447), and select UnitedHealthcare, then 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 Cancer Resource Services network at the time the treatment or service is given.

When the above services have been authorized by CRS and provided at a CRS Center of Excellence facility, you will not have to make any copayments for services rendered at the Center. Also, once enrolled in the Program, when the facility is more than 100 miles from the patient's home, a travel, lodging and meals benefit is available to the patient and one travel companion. Available coach airfare is covered when the CRS Center of Excellence facility is more than 200 miles from the patient's home.

**Enrollment.** To receive the paid-in-full benefit and the travel benefit, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447). Select UnitedHealthcare and then Cancer Resource Services to enroll in the Program.

**Other benefits still available.** The Centers 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 UnitedHealthcare. Covered hospital services may be available through Empire BlueCross BlueShield. 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.

*Substitute the following for "A." of "How" and "A." of "When" in the "How, When and Where to Submit Claims" section on pages 99-100 of your UnitedHealthcare Certificate.*

**Claims: How**

A. If you go to a participating provider or MPN Network provider, or a Basic Medical Provider Discount Program provider, all you have to do is ensure that the provider has accurate and up-to-date personal information—name, address, identification number, signature—needed to complete the claim form. Your participating provider, MPN Network provider, HCAP-approved provider or Discount Program provider fills out the form and sends it directly to UnitedHealthcare. The claim forms are in each provider's office.

**Claims: When**

A. If you use a participating provider, MPN Network provider, HCAP Network provider or a Basic Medical Provider Discount Program provider, your provider will submit a claim to UnitedHealthcare.

# GHI CERTIFICATE OF INSURANCE
# Empire Plan Mental Health and Substance Abuse Program

*Substitute the following for the GHI Certificate of Insurance on pages 107-130 of your Empire Plan Certificate.*

## Certificate of Insurance
## Group Health Incorporated

**(Herein referred to as GHI)**

**441 Ninth Avenue**
**New York, New York 10001**

GHI certifies that under and subject to the terms and conditions of Group Policy PLH-5244-D issued to

**State of New York**

**(Herein called the State)**

each eligible Enrollee shall become insured on the Enrollee's own account and on account of each of the Enrollee's eligible Dependents for the coverage described in this Certificate, on the later of:

A. October 1, 2007 or

B. The date determined in accordance with the Regulations of the President of the Civil Service Commission.

The benefits under this Program do not at any time provide paid-up insurance, or loan or cash values.

No agent has the authority:

A. To accept or to waive any required notice or proof of a claim; nor

B. To extend the time within which any such notice or proof must be given to GHI.

This Certificate may not be assigned by the Enrollee. An Enrollee's benefits may not be assigned prior to a loss.

The insurance evidenced by this Certificate does NOT provide basic hospital insurance, basic medical insurance or major medical insurance as defined by the New York State Insurance Department.

Group Health Incorporated
Form No. PLH-5244
Group Health Incorporated
Certificate of Insurance

# Section IV
# GHI CERTIFICATE OF INSURANCE
## Mental Health and Substance Abuse Program

### Overview

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

Review the benefits and exclusions in this Certificate before you obtain services. Excluded services and conditions will not be covered under the Program. If your inpatient or outpatient treatment is found not medically necessary, you will not receive any Empire Plan benefits, and you will be responsible for the full cost of care.

### Coverage

Covered services for mental health and substance abuse care, including care for alcoholism, include:

- Emergency assessments at all times;
- Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge;
- Alternatives to inpatient care (such as certified residential treatment facilities and certified halfway houses, etc.);
- Outpatient mental health services;
- Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment;
- Substance abuse structured outpatient rehabilitation and aftercare;
- Electro-convulsive therapy;
- Medication management;
- Ambulance services; and
- Psychiatric second opinions.

### You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions


**Before** you seek non-emergency mental health or substance abuse care, including treatment for alcoholism, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions. You should call within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

If you do not call, or if you call but do not follow ValueOptions' recommendations, you may receive a lower level of benefits for non-emergency services.

Calling ValueOptions is the first step in ensuring that you will be eligible to receive the highest level of benefits. ValueOptions is always open, 24 hours a day, every day of the year.

The Empire Plan Mental Health and Substance Abuse Program has two levels of benefits for covered services: network coverage and non-network coverage.

### Highest level of benefits when you call and follow ValueOptions' recommendations

**You qualify for network coverage when:**

- You call ValueOptions before your treatment begins, and
- You are treated by a provider ValueOptions recommends.

Usually, you will be referred to a network provider or facility. However, you will still qualify for network coverage if ValueOptions refers you to a non-network provider or facility.

### Lower benefits when you don't call ValueOptions, you don't use a recommended provider

Benefits are available for medically necessary care when you don't use ValueOptions. These benefits are lower than those available when you call ValueOptions and seek care from a recommended provider.

**You will receive non-network coverage for covered services when:**

- You do not call ValueOptions, and/or
- You call ValueOptions but do not follow their recommendations.

The mental health and substance abuse care you obtain will be covered by GHI only if it meets the conditions for coverage stated in this Certificate. Read this entire Certificate in order to understand the Program.

Program benefits and responsibilities apply to you and your enrolled dependents whenever you seek Empire Plan coverage for these services, even if you have Medicare or other health insurance coverage, as well.

Key terms are used throughout the Certificate. Read the section of the Certificate called *"Meaning of Key Terms"* for definitions of these terms.

**If you have questions about The Empire Plan Mental Health and Substance Abuse Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions. TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-334-1897.**

## Meaning of Key Terms

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

A. **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by ValueOptions.

   Under network coverage, residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by ValueOptions.

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

C. **Certification or Certified** means a determination by ValueOptions that mental health care or substance abuse care or proposed care is a medically necessary, covered service in accordance with the terms of this Certificate.

D. **Clinical Referral Line** means the clinical resource and referral service which you must call prior to receiving any covered services. You may call 24 hours a day, every day of the year. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions.

E. **Coinsurance** means, for Approved Facility services, the difference between the billed charge and the percentage covered; and, for Practitioner services, the difference between the reasonable and customary charge and the percentage covered. Coinsurance applies to non-network Mental Health covered services.

F. **Concurrent Review** means ValueOptions' utilization review and medical management program under which ValueOptions reviews the medical necessity of mental health care and substance abuse services. ValueOptions' review is conducted by a team of licensed psychiatric nurses, social workers, board-certified or board-eligible psychiatrists and clinical psychologists, to determine whether proposed services are medically necessary for your diagnosed condition(s). This program includes combined outpatient and inpatient review as described in this Certificate.

G. **Copayment** means the amount you are required to pay for covered services you obtain from a network provider for outpatient services under the Mental Health and Substance Abuse Program. Please refer to the *"Schedule of Benefits for Covered Services"* for the exact amount of copayment. Copayment applies only to network coverage except for non-network emergency room covered services.

H. **Course of Treatment** means the period of time, as determined by ValueOptions, required to provide mental health and substance abuse care to you for the resolution or stabilization of specific symptoms or a particular disorder. A course of treatment may involve multiple providers.

I. **Covered Services** means medically necessary mental health and substance abuse care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.

J. **Covered Expenses** means:

1. For Mental Health and Substance Abuse care under the network portion of the Program, the network allowance for any medically necessary covered services provided to you under the Program by a network provider.
2. For Substance Abuse care under the non-network portion of the Program, the non-network allowance for medically necessary covered services provided to you under the Program by a non-network provider. No more than the non-network allowance will be considered by the Program for medically necessary covered services.
3. For Mental Health care under the non-network portion of the Program, the Reasonable and Customary charge for medically necessary covered services provided to you under the Program by a non-network Practitioner. No more than the Reasonable and Customary charge less coinsurance will be considered by the Program for medically necessary covered services.
4. For Mental Health care under the non-network portion of the Program, the billed amount for medically necessary covered services provided to you under the Program by a non-network Approved Facility. No more than the billed amount less coinsurance will be considered by the Program for medically necessary covered services.

   A covered expense is incurred on the date you receive the service.

K. **Crisis Intervention Visits** means visits for treatment of an acute emotional disturbance which results in a temporary inability to function in one's daily life.

Examples of situations meeting this definition include:

1. An acute psychotic reaction,
2. Loss of coping capacity, and
3. Any situation endangering the patient, others or property.

Such crisis is usually precipitated by an adverse event such as:

1. Loss of crucial person through death, divorce or separation,
2. Serious illness, accident or sudden heart attack,
3. Onset of disabling psychiatric symptoms, or
4. A social trauma such as rape or robbery.

L. **Deductible** means the amount you must pay each calendar year for covered services under the non-network portion of the Mental Health and Substance Abuse Program before payment will be made to you. Deductibles apply only to the non-network coverage. The Substance Abuse outpatient deductible, the Substance Abuse inpatient deductible, and the Mental Health outpatient deductible are separate deductibles and cannot be combined.

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

1. The amount you actually paid for a medically necessary service or supply covered under the non-network portion of the Program; or
2. For Substance Abuse services, the non-network allowance for such service or supply;
3. For Mental Health Practitioner services, the reasonable and customary charge less coinsurance for such service; or
4. For Mental Health Approved Facility services, the billed amount less coinsurance for such service.

The Mental Health and Substance Abuse Program deductibles are separate from the Basic Medical and Managed Physical Medicine Program annual deductibles. The mental health and substance abuse deductibles cannot be combined with any other deductible or out-of-pocket provision.

M. **Emergency Care** is care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

N. **GHI** means Group Health Incorporated, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.

O. **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.

P. **Medically Necessary** means a service which ValueOptions has certified to be:

1. Medically required;
2. Having a strong likelihood of improving your condition; and
3. Provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted psychiatric and mental health practices and the professional and technical standards adopted by ValueOptions.

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

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

Q. **Mental Health Care** means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of ValueOptions, is directed predominately at treatable behavioral manifestations of a condition that ValueOptions determines:

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

R. **Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you under the network provider portion of the Program.

S. **Network Coverage** means the higher level of benefits provided by the Program when you receive medically necessary services from a provider recommended to you by ValueOptions.

T. **Network Facility** means an approved facility that has entered into a network provider agreement as an independent contractor with ValueOptions. The records of ValueOptions shall be conclusive as to whether an institution has a network provider agreement in effect on the date that you obtain services. A non-network facility can be considered a network facility on a case-by-case basis when approved by ValueOptions.

U. **Network Practitioner** means a practitioner who has entered into an agreement with ValueOptions as an independent contractor to provide covered services to you. The records of ValueOptions shall be conclusive as to whether a person had a network provider agreement in effect on the date that you obtained services. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by ValueOptions.

V. **Network Provider** means either a network practitioner or a network facility.

W. **Non-network Allowance** means the lower of the following:

1. The amount you actually paid for a Substance Abuse service or supply covered under the non-network portion of the Program; or
2. **For a Facility:** 50 percent of the average network allowance of all ValueOptions network facilities in the county where you receive Substance Abuse care. If there are no network facilities in the county where you receive care, or if you receive care outside New York State, the non-network allowance will be 50 percent of the average ValueOptions network allowance for New York State. County-specific and statewide-average network allowances will be computed by ValueOptions annually.

   **For a Practitioner:** 50 percent of the network allowance for the Substance Abuse service you receive.

The non-network allowance for a service or supply is determined by ValueOptions according to established guidelines. The non-network allowance is used as a basis for determining the amount of Program

benefits you are entitled to receive for any Substance Abuse service or supply you obtain under the non-network portion of the Program. See *"Schedule of Benefits for Covered Services"* for a full explanation of how the amount of non-network coverage is determined.

X. **Non-network Coverage** means the lower 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.

Y. **Non-network Facility** means an approved facility that has not entered into an agreement with ValueOptions to provide covered services to you.

Z. **Non-network Provider** means a practitioner or approved facility that has not entered into an agreement with ValueOptions to provide covered services to you.

AA. **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.

BB. **Partial Hospitalization** (day or night care center) means a visit in a center maintained by an approved facility that has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program.

CC. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who maintains an active clinical practice and who renders medical necessity decisions on questionable cases.

DD. **Practitioner** means:

1. A psychiatrist; or
2. A psychologist; or
3. A licensed and registered social worker with at least six years of post-degree experience who is qualified by the New York State Board for Social Work. In New York State, this is determined by the "R" number given to qualified social workers. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or
4. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist; or
5. A Registered Nurse Practitioner: a nurse with a Master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided; must be certified and have a practice agreement in effect with a network physician.
6. A professional corporation;
7. A university faculty corporation.

EE. **Program** means The Empire Plan Mental Health and Substance Abuse Program. This Program provides coverage under Group Policy No. PLH-5244-D issued to the State of New York, the policyholder, by GHI.

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

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

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

1. The actual charge for Mental Health services; or
2. The usual charge for Mental Health services by the Practitioner; or
3. The usual charge for Mental Health services of other Practitioners of similar training or experience in the same or similar geographic area for the same or similar service.

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

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

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

A Structured Outpatient Rehabilitation Program is a program in which the patient participates, on an outpatient basis, in prescribed formalized treatment, which includes an intensive phase involving more than once-weekly treatment, as well as an aftercare component, which includes weekly follow-up/support visits. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

JJ. **Substance Abuse Care** means medically necessary care provided by an eligible provider for the illness or condition that ValueOptions has determined:

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

KK. **ValueOptions** is the company selected by the State of New York to administer The Empire Plan Mental Health and Substance Abuse Program. ValueOptions provides services for GHI in the administration of this Program.

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

## How to Receive Benefits for Mental Health and Substance Abuse Care

### You must call

Before you seek treatment for mental health or substance abuse, including alcoholism, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions, even if another plan is your primary coverage.

You must call ValueOptions even when a doctor refers you to a mental health professional or facility. You may ask ValueOptions to refer you to a particular provider. However, ValueOptions will determine the appropriateness of this referral.

The advantages of making this call are:

- You will receive help in choosing the right provider. You don't have to guess which professional can help you.
- You will have access to an extensive network of quality providers in your area, carefully chosen for their training and experience.
- You may reduce out-of-pocket expenses and you can get the recommended care without worrying about the bill. Except for any copayments, the bill is paid when you follow ValueOptions' recommendation, and there are no claim forms.
- When you use ValueOptions for intervention following a significant life crisis, such as a death, trauma, divorce, illness or work and life issues, you are eligible for up to three outpatient visits without a copayment.
- You will receive confidential help - no one needs to know you are making the call.

### The ValueOptions network and the referral process

The Mental Health and Substance Abuse Program has two levels of benefits: network coverage and non-network coverage. By following the Program requirements for network coverage, you will receive the highest level of benefits. Please refer to the *"Schedule of Benefits for Covered Services"* for a complete description of the two benefit levels.

ValueOptions' network gives you access to a wide range of providers when you need mental health or substance abuse care. These providers are in your community and many of them have been caring for Empire Plan enrollees and their families for years.

### Program requirements apply nationwide, even if another plan is your primary coverage

You must follow the requirements for the Mental Health and Substance Abuse Program whenever you will be seeking Empire Plan coverage for these services. You must follow Program requirements even if Medicare or another health insurance plan is your primary coverage. Program requirements apply nationwide regardless of where you seek mental health and substance abuse services.

### Program requirements for network coverage

In order to receive network coverage, the highest level of benefits:

- You must call ValueOptions before outpatient treatment begins. You must call ValueOptions before you are admitted as an inpatient. (Requirements are different for an emergency. See *"Emergency Services"*.) **and**
- You must be treated by a provider or admitted to a facility recommended to you by ValueOptions.

When you follow these requirements for network coverage, the network provider will be responsible for obtaining certification from ValueOptions. Both you and

your provider will receive written confirmation from ValueOptions indicating the care (number of visits or length of stay) that has been certified.

### Lower benefits apply if you don't call ValueOptions or if you don't use a recommended provider

Benefits are available for medically necessary care when you do not follow the Program requirements for network coverage. These benefits are lower than those available when you call ValueOptions and seek care from a recommended provider. See the *"Schedule of Benefits for Covered Services"* for a description of non-network coverage.

Before you choose a non-network provider, consider the high cost of treatment.

### Program requirements if you choose to use a non-network provider

For a non-emergency inpatient admission to a non-network facility, you must call ValueOptions before the admission to have the medical necessity of the admission certified.

If you choose a non-network provider for outpatient treatment, call ValueOptions early in your treatment so that ValueOptions can begin the process of determining whether your treatment will be covered. You must call before the sixth visit to begin the certification process. ValueOptions must certify any outpatient visits beyond the tenth such visit during any course of treatment.

When you use a non-network provider, you are responsible for obtaining certification from ValueOptions. You will receive written confirmation from ValueOptions indicating the care (number of visits or length of stay) which has been certified.

### Emergency services

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

You must pay the first $60 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this $60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

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

### Call ValueOptions

You or a member of your family or household may place the call to The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions. In the case of an emergency or urgent situation, your doctor, a member of your doctor's staff, or the hospital admitting office, may place the call for you. Where this Certificate refers to "you" making the call, keep in mind that other people listed may also call. **But it is your responsibility to see that the call is made.**

### Clinical Referral Line

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions for referrals to providers. Whenever you or your family faces a mental health or substance abuse problem, including alcoholism, getting help begins with a call to ValueOptions. By making the call before you receive services, and then obtaining care from a provider referred to you by ValueOptions, you will qualify for network coverage. Usually, ValueOptions will refer you to a network practitioner or network facility. However, you will also qualify for network coverage if no network provider is available and ValueOptions refers you to a non-network provider.

The Clinical Referral Line is available 24 hours a day, every day of the year. It is staffed by clinicians who have professional experience in the mental health and substance abuse field. These highly trained and experienced clinicians are available to help you determine the most appropriate course of action.

### Call when you use a non-network provider

To be certain that your care is medically necessary when you choose to use a non-network provider, you must call ValueOptions to start the certification process. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions between 8 am and 5 pm Eastern time on business days and select the Customer Service Line. Ask ValueOptions to mail an Outpatient Treatment Report to your non-network provider. If you do not call when you use a non-network provider, and your inpatient or outpatient treatment is not found to be medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

### Show your identification card

You must show your identification card every time you request covered services from network providers. Possession and use of an identification card is not entitlement to benefits. Coverage for benefits is subject to verification of eligibility for the date covered services are rendered, and all the terms, conditions, limitations and exclusions set out in this Certificate.

### Release of medical records

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

## Concurrent Review

### ValueOptions reviews treatment

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

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

ValueOptions must continue to certify the medical necessity of your care for your Empire Plan benefits to continue.

If ValueOptions determines that inpatient treatment is no longer necessary, ValueOptions will notify you, your doctor and the facility no later than the day before the day on which inpatient benefits cease. ValueOptions will assist you in making the transition from inpatient care to the appropriate level of treatment with a network provider.

### Certification denial and appeal process: deadlines apply

Only a ValueOptions peer advisor can deny certification. If certification for any covered service is denied, ValueOptions will notify you and the applicable provider of the denial and provide information on how to request an appeal of such decision by telephone. You will have 60 days to request an appeal.

When you or your provider requests an appeal of ValueOptions' decision to deny certification, another ValueOptions 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 ValueOptions peer advisor in a telephone review. You and your provider will be advised in writing of ValueOptions' decision.

If the peer advisor's determination is to continue to deny certification, you and your provider will be provided with written information on how to request a second level appeal of ValueOptions' decision. You have 30 days from the date of your receipt of ValueOptions' written denial notice to request a second level appeal.

Level II clinical appeals are conducted by a panel of two board-certified psychiatrists, one from ValueOptions and one from GHI, and a Clinical Manager. Panel members have not been involved in the previous determinations of the case. Administrative appeals are reviewed by ValueOptions, in consultation with GHI as needed. A determination will be made within 10 business days of the date ValueOptions received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision. See *"Appeals: 60-day deadline"* for additional information.

## What is Covered Under the Mental Health and Substance Abuse Program

This section describes Program coverage for inpatient and outpatient care.

### Inpatient care

Coverage for inpatient care includes the following medically necessary services:

A. **Hospital Services** for the treatment of mental health and substance abuse are covered.

B. **Residential Treatment Facilities, Halfway Houses and Group Homes.** Covered charges will be payable in full under the network coverage if the admission is certified by ValueOptions. Confinements for these services are covered only under the network portion of the Program. **No benefits are available under non-network coverage.**

C. Mental health care in a **partial hospitalization** program (day or night care center), maintained by an approved facility, on its premises, is covered.

D. **Psychiatric Treatment or Consultation While You Are a Mental Health, Substance Abuse or Medical Inpatient in an Approved Facility.** If you are receiving inpatient mental health/substance abuse treatment from a practitioner who bills separately from the hospital or approved facility, you are covered for no more than one visit per day by your practitioner unless medically necessary. This care must be certified independently of the inpatient stay.

   If you are admitted to a hospital for a medical condition and the admission interrupts your certified outpatient mental health and substance abuse care, you may continue to receive certified care from your practitioner during your inpatient stay.

E. **Inpatient Psychiatric Consultations on a Medical Unit.** You are covered for no more than one inpatient mental health visit per day by a practitioner unless medically necessary while you are on the medical unit of a hospital.

### Outpatient care

Coverage for outpatient care includes the following medically necessary services:

A. **Emergency Care** at a hospital for treatment of mental health/substance abuse, 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 general mental health care. A maximum of one visit per day to the same practitioner will be considered to be a covered service.

C. **Psychiatric Second Opinion.** You are covered for second opinions by a practitioner of equal or higher credentials. Example: Only another psychologist or a psychiatrist may give a second opinion on a psychologist's diagnosis.

D. **Family Sessions.** For each patient's alcoholism, alcohol abuse, or substance abuse treatment program, benefits are allowed for covered family sessions. When the covered alcoholic, alcohol abuser or substance abuser is participating in a Structured Outpatient Substance Abuse Rehabilitation Program, up to 20 family sessions (per calendar year) for family members covered under the same Empire Plan enrollment are included in the program. If the alcoholic, alcohol abuser, or substance abuser is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are eligible for up to 20 family sessions (per calendar year), subject to ValueOptions certification.

E. **Substance Abuse-Structured Outpatient Rehabilitation Program.** Covered benefits are allowed for substance abuse Structured Outpatient Rehabilitation Programs.

F. **Psychological Testing and Evaluations.** These services are covered if ValueOptions requests them and determines that they are medically necessary for the condition(s) indicated. If these services are provided on an outpatient basis, the network provider **must** obtain ValueOptions certification of this care before testing begins. If testing is being provided by a non-network provider, you **must** have your practitioner call ValueOptions and obtain certification of the care before testing begins. There are no network or non-network benefits available if testing is not certified by ValueOptions in advance.

G. **Ambulance Services for Mental Health and Substance Abuse Care.** You are covered for medically necessary hospital-based ambulance services, commercial ambulance services or organized voluntary ambulance services for transfers from non-network facilities to network facilities approved in advance by ValueOptions. You are also covered for emergency transport to an approved facility.

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

H. **Crisis Intervention Visits.** Crisis intervention visits are covered under the network coverage and will be payable in full up to the network allowance for up to three visits in a given crisis. ValueOptions reviews documentation of each crisis for approval.

   A statement of necessity satisfactory to ValueOptions must be submitted by the network provider in order for a period of treatment to be considered a crisis.

   **Paid-in-full benefits for these services are available under network coverage only.**

I. **Electro-convulsive Therapy.** Electro-convulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All electro-convulsive therapy must be certified by ValueOptions before the service is received.

J. **Medication Management.** You are covered for office visits to a psychiatrist specializing in psychopharmacology for the ongoing review and monitoring of psychiatric medications.

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

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

M. **Telephone Counseling.** Telephone counseling provided by a network practitioner is covered. **Benefits for these services are available under network coverage only.**

**VALUEOPTIONS MUST CERTIFY ALL COVERED SERVICES AS MEDICALLY NECESSARY. IF VALUEOPTIONS DOES NOT CERTIFY YOUR INPATIENT OR OUTPATIENT TREATMENT AS MEDICALLY NECESSARY, YOU WILL NOT RECEIVE ANY EMPIRE PLAN BENEFITS AND YOU WILL BE RESPONSIBLE FOR THE FULL COST OF CARE.**

### NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

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

A. No copayments are required for inpatient care.

B. You pay the first $18 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.

C. You pay the first $18 charged for any other outpatient visit including Home-Based and Telephone Counseling in place of an office visit, except no copayment is required for:
- Crisis Intervention, up to three visits per crisis
- Electro-convulsive Therapy - facility and therapist charges, if certified by ValueOptions
- Psychiatric Second Opinion, if requested and certified by ValueOptions
- Ambulance Service
- Mental Health Psychiatric Evaluations, if requested and certified by ValueOptions
- Prescription drugs, if billed by an approved facility
- Home-based counseling when provided in place of inpatient care.

D. You pay the first $60 charged for emergency care in a hospital emergency room. You will not have to pay this $60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

The network provider from whom you receive covered services is responsible for collecting the copayment from you.

**(continued on next page)**

### YOU ARE RESPONSIBLE FOR OBTAINING VALUEOPTIONS CERTIFICATION FOR CARE OBTAINED FROM A NON-NETWORK PROVIDER

### NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE

If you do NOT follow the requirements for network coverage, GHI pays the following covered percentages:

A. For Practitioner Services: Up to 80 percent of reasonable and customary charges for covered services after you meet the annual deductible for outpatient practitioner services which is $335 per enrollee, $335 per covered spouse/domestic partner and $335 for all covered dependent children combined. After a coinsurance maximum is reached of $1,241 per enrollee and covered dependents combined, the Plan pays up to 100 percent of reasonable and customary charges for covered services. The annual deductible and annual coinsurance maximum will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I) for Urban Wage Earners and Clerical Workers, all Cities, C.P.I.-W) for the period of July 1 through June 30 of the preceding year. Deductibles do not count towards the coinsurance maximum.

B. For Approved Facility Services: Up to 90 percent of billed charges for covered services. After a coinsurance maximum is reached of $500 for you, the enrollee, $500 for your enrolled spouse/domestic partner and $500 for all enrolled dependent children combined, GHI pays 100 percent of billed charges for covered services.

ValueOptions will consider non-network coverage for covered expenses after you meet your annual deductible. You are responsible for the coinsurance amount up to the coinsurance maximum. And, for practitioner services, any charges in excess of the reasonable and customary charge.

**(continued on next page)**

**NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE (continued)**

**Note** - Copayments do **NOT** count toward meeting your non-network coverage deductibles, Basic Medical deductible or Basic Medical Coinsurance Maximum. Copayments count toward meeting your Mental Health non-network outpatient practitioner coinsurance maximum.

Except for the copayment that the network provider obtains directly from you, a network provider does not bill you directly for services or supplies you obtain as a network benefit. Your payment to the network provider is limited to the copayment. The network provider requests payment directly from GHI.

**Maximums**

A. Network coverage is unlimited (no maximum) for outpatient mental health and substance abuse care.

B. Network coverage is unlimited (no maximum) for inpatient services for mental health.

C. Inpatient services for treatment of substance abuse are covered for a maximum of three stays per lifetime. Further stays will be considered on a case-by-case basis.

   If a patient transfers from one facility to another, the confinement ends upon discharge from the original facility, unless ValueOptions arranges for the transfer. If ValueOptions arranges for the transfer, treatment at the new facility will be considered a continuation of the same stay.

D. Psychiatric treatment provided by an individual practitioner while you are a mental health, substance abuse or medical inpatient is covered for one visit per day when medically necessary.

**Note** - The amount you pay for inpatient and outpatient services does **NOT** count toward meeting your Basic Medical deductible or Basic Medical coinsurance maximum. Deductible amounts that you pay for outpatient Mental Health services count towards satisfying your outpatient Substance Abuse deductible. No other deductible, coinsurance or maximum coinsurance amount may be counted toward satisfying any other deductible, coinsurance or maximum coinsurance amount.

**NON-NETWORK COVERAGE FOR SUBSTANCE ABUSE CARE**

If you do NOT follow the requirements for network coverage, you are responsible for paying the following:

A. The annual deductible for non-network outpatient services, which is $500 per enrollee, $500 per covered spouse/ domestic partner and $500 for all covered dependent children combined, regardless of the number of children.

B. The annual deductible for non-network inpatient services, which is $2,000 per enrollee, $2,000 per covered spouse/ domestic partner and $2,000 for all covered dependent children combined, regardless of the number of children.

ValueOptions will consider non-network coverage for covered expenses after you meet your annual deductible. The non-network allowance is 50 percent of the network allowance.

**Note** - The amount you pay for inpatient and outpatient services does NOT count toward meeting your Basic Medical deductible or Basic Medical coinsurance maximum. Amounts you pay for Non-Network Substance Abuse services do not count towards Mental Health deductibles, coinsurance or coinsurance maximums.

**Maximums**

After you meet your Substance Abuse Program deductible, you will be reimbursed up to the non-network allowance, subject to the following maximums:

A. Outpatient services for treatment of substance abuse (including alcohol) are covered up to a maximum of 30 visits in a calendar year, inclusive of Structured Outpatient Rehabilitation Programs and emergency room visits.

**(continued on next page)**

B. Inpatient services for treatment of substance abuse (including alcohol) are covered for a maximum of one confinement in any calendar year and three admissions per lifetime.

   If a patient transfers from one facility to another, the confinement ends upon discharge from the original facility unless ValueOptions arranges for the transfer. If ValueOptions arranges for the transfer, treatment at the new facility will be considered a continuation of the same stay.

C. The annual maximum benefit for substance abuse care, including alcoholism, under the non-network coverage is $50,000 for you, the enrollee, and $50,000 for each of your covered dependents.

D. The lifetime maximum benefit for substance abuse care, including alcoholism, under the non-network coverage is $250,000 for you, the enrollee, and $250,000 for each of your covered dependents.

E. Outpatient treatment sessions for family members of an alcoholic, alcohol abuser, or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

## Exclusions and Limitations

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

A. Expenses incurred prior to your effective date of coverage or after termination of coverage, except under conditions described in the *"Miscellaneous Provisions"* section.

B. Services or supplies which are not Medically Necessary as defined in the section *"Meaning of Key Terms"*.

C. Treatment which is not Mental Health Care or Substance Abuse Care as defined in the section *"Meaning of Key Terms"*.

D. Services or supplies which 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 which may be a focus of clinical attention (V codes); except for family visits for substance abuse or alcoholism.

F. Services deemed Experimental or Investigational are not covered under this Plan. However, ValueOptions and GHI may deem an Experimental or Investigational Service is covered under this Plan for treating a life-threatening sickness or condition if they determine that the Experimental or Investigational Service at the time of the determination:
   - Is proved to be safe with promising efficacy; and
   - Is provided in a clinically controlled research setting; and
   - Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

G. Custodial care, except when medically necessary. Custodial care means the spectrum of services and supplies provided expressly for protection and monitoring in a controlled environment, regardless of setting, and assistance to support essentials of daily living in patients whose persistent symptoms, behavior management, and/or medical and psychological problems result in serious ongoing impairment in central life role function. Such care includes, but is not limited to, state hospital care which is custodial for children who are wards of the state or for enrollees or eligible dependents who are incarcerated in a state hospital facility.

H. Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered.

I. Private duty nursing.

J. Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient treatment reports and statements of medical necessity.

K. Charges for services, supplies or treatments that are covered charges under any other portion of The Empire Plan, including but not limited to detoxification of newborns and medically complicated detoxification cases.

L. Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.

M. Services or supplies you receive for which no charge would have been made in the absence of coverage under the Mental Health and Substance Abuse Program, including services from an Employee Assistance Program.

N. Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.

O. Any charges for professional services performed by a person who ordinarily resides in your household or who is related to you, such as a spouse, parent, child, brother or sister or by an individual or institution not defined by ValueOptions as a provider.

P. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you, to the extent that medical expenses are identified in the judgment or settlement.

Q. Conditions resulting from an act of war (declared or undeclared) or an insurrection which occurs after December 5, 1957.

R. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Abuse Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

## Coordination of Benefits

If you are covered by an additional group health insurance program (such as a program provided by your spouse's employer) which contains coverage for mental health or substance abuse, The Empire Plan will coordinate benefit payments with the other program. One program pays its full benefit as the primary insurer and the other program pays secondary benefits.

Coordination of benefits helps ensure that you receive all the benefits to which you are entitled from each plan, while preventing duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge.

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

The procedures followed when Empire Plan benefits are coordinated with those provided under another program are detailed below. Each of The Empire Plan carriers follows these procedures.

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

B. Definitions

1. "Plan" means a plan which provides benefits or services for or by reason of mental health or substance abuse care and which is:
   a. A group insurance plan; or
   b. A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or

c. A self-insured or non-insured plan; or
d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
e. A group service plan; or
f. A group prepayment plan; or
g. Any other plan which covers people as a group; or
h. A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan; or
i. A mandatory "no fault" automobile insurance plan.

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

Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan which 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 which do not.

C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for the service you receive.

D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has coordination of benefits or similar provision with the same order of benefit determination as stated in Item E. Empire Plan benefits are to be determined, in that order, before the benefits under the other plan.

E. When more than one plan covers the person making the claim, the order of benefit payments is determined using the first of the following rules which applies:

1. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
2. When this plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are not divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph on page 201.)
   a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
   b. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
   c. If the other plan does not have the rule described in subparagraphs a. and b. above, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
   d. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child; and
   c. Finally, the plan of the parent not having custody of the child; and
   d. 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 which 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 which 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. above determined the order of benefits, the plan which 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 which is needed to apply this provision may be given or received without consent of or notice to any person, subject to the provisions in Article 25 of the General Business Law.

H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, The Empire Plan carriers have the right to recover the overpayment. You will be required to return any overpayment to the appropriate Empire Plan carrier; or at GHI's discretion, future benefits may be offset by this amount. In most cases, this will be the amount that was paid by the other plan.

I. If payments which should have been made under The Empire Plan have been made under other plans, the party that paid will have the right to recover the appropriate amount from The Empire Plan carriers.

J. There is a further condition which applies under the network provider program. When either Medicare or a plan other than The Empire Plan pays first, and if for any reason the total sum reimbursed by the other plan and The Empire Plan is less than the network provider billed the other plan, the network provider may not charge the balance to you.

## Impact of Medicare on this Plan

Even if Medicare or another plan provides your primary coverage, you must follow ValueOptions' requirements whenever you will be seeking Empire Plan coverage for mental health or substance abuse services.

### Definitions

A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.

B. **Primary Payor** means the plan that will determine the medical benefits which 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 section of this 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 the General Information section of this 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 available under Medicare, and GHI will consider the balance for payment, subject to copayment, deductible and coinsurance.**

**If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained in the last paragraph of this section, *"Medicare Advantage Plans and your Empire Plan coverage"* below.**

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 GHI will consider the balance for payment, subject to copayment, deductible and coinsurance.

If the provider has agreed to accept Medicare assignment, covered expenses will be based on the provider's reasonable charge or the amount approved by Medicare, whichever is less. If the provider has not agreed to accept Medicare assignment, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations.

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

B. **Active State Employees and/or their Dependents** – This Plan will automatically be the primary payor for active employees, regardless of age, and for the employee's enrolled dependents (except for a domestic partner eligible for Medicare due to age) unless end-stage renal disease provisions apply; Medicare, the secondary payor. As the primary payor, GHI 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 to domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

C. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must be enrolled in Parts A and B of Medicare when first eligible and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.

D. **End-Stage Renal Disease**. For those eligible for Medicare due to end-stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first 30 months of treatment, then Medicare becomes primary. See *"Medicare end-stage renal disease coordination"* in the General Information section. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

E. **Veterans' Facilities.** Where services are provided in a U.S. Department of Veterans' Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a non-governmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan's benefits. The Medicare amount payable is the amount that would be payable to a Medicare-eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a non-governmental facility.

### Medicare Advantage Plans and your Empire Plan coverage

If you or your dependent enrolls in a Medicare Advantage plan, in addition to your Empire Plan coverage, The Empire Plan will not provide benefits for any services available through your Medicare Advantage plan or services that would have been covered by your Medicare Advantage plan if you had complied with the plan's requirements for coverage. Covered medical expenses under The Empire Plan are limited to expenses not covered under your Medicare Advantage plan. If your Medicare Advantage plan has a Point-of-Service option that provides partial coverage for services you receive outside the plan, covered medical expenses under The Empire Plan are limited to the difference between the Medicare Advantage plan's payment and the amount of covered expenses under The Empire Plan.

## Claims

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

### 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, GHI will make any payment due under this Program directly to the provider, except for the copayment amount which you pay to the provider.

B. **Non-network Coverage:** When you receive non-network coverage, any payment due under the Program will be made **ONLY** to you. You are responsible for payment of charges at the time they are billed to you. You must file a claim with ValueOptions for services rendered under non-network coverage in order to receive reimbursement. GHI pays you the non-network covered amount for the covered service you obtained.

You are always required to pay the inpatient and/or outpatient 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 GHI. However, GHI may pay the non-network covered amount directly to an approved facility in lieu of paying you.

C. **Assignment Prohibited:** Your right under this Program to receive reimbursement for outpatient covered services when such services are provided under non-network coverage, except inpatient services and partial hospitalization where agreed to by GHI, may not be assigned or otherwise transferred to any other person or entity including, without limitation, any such provider. Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, GHI or ValueOptions.

## How, When and Where to Submit Claims

### How

If you use network coverage, all you have to do is ensure that the provider has accurate and up-to-date personal information needed to complete the claim form - name, address, identification number, signature. Your provider fills out the form and sends it directly to ValueOptions. The claim forms are generally in each provider's office.

If you use non-network coverage, you must submit a claim. You may obtain a claim form from:

ValueOptions
P.O. Box 778
Troy, New York 12181-0778

or

You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions.

For non-network coverage, have the 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, the bills must include all the information asked for on the claim form. Missing information will delay processing of your claim. No benefits will be paid unless care is certified by ValueOptions.

### 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. 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.**

A. If you use network coverage, your provider will submit a claim to ValueOptions.

B. If you use non-network coverage, you must meet the Mental Health and Substance Abuse Program annual deductible before the claims are paid. This deductible is separate from the other Empire Plan annual deductibles.

**Claims must be submitted to either ValueOptions or Medicare, if applicable, within 90 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 ValueOptions within 90 days after Medicare processes the claim.**

**Benefits will not be paid for claims submitted after the 90 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).**

### Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an *"Explanation of Medicare Benefits"* form to: ValueOptions, P.O. Box 778, Troy, New York 12181-0778.

### Fraud

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

### Verification of claims information

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

### Questions

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose ValueOptions.

### COBRA: Continuation of Coverage

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

## Miscellaneous Provisions

### Confined on effective date of coverage

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

### Benefits after termination of coverage

If you are Totally Disabled due to a mental health or substance abuse condition on the date coverage ends on your account, GHI will pay benefits for covered expenses for that Total Disability, on the same basis as if coverage had continued without change, until the day you are no longer Totally Disabled or 90 days after the day your coverage ended, whichever is earlier.

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

### Confined on date of change of options

"Option" means your choice under the New York State Health Insurance Program of either The Empire Plan, which includes the Mental Health and Substance Abuse Program, or a Health Maintenance Organization (HMO). See your NYSHIP General Information Book for information on option transfer.

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

A. If the transfer is out of The Empire Plan, and you are confined on the day coverage ends, benefits will end on the effective date of option transfer; and

B. If the transfer is into The Empire Plan, benefits under the Mental Health and Substance Abuse Program are payable for covered expenses to the extent they exceed or are not paid through your former HMO.

### Termination of coverage

A. Coverage will end when you are no longer eligible to participate in The Empire Plan. Refer to your NYSHIP General Information Book.

B. If this Program ends, your coverage will end.

C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your NYSHIP General Information Book.

D. If a payment which 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 which is incurred before your coverage ends will not be affected.

### Refund to GHI for overpayment of benefits

If GHI pays benefits under this Program for covered expenses incurred on your account, and it is found that GHI paid more benefits than should have been paid because all or some of those expenses were not paid by you, or you were also paid for all or some of those expenses by another source, GHI will have the right to a refund from you.

The amount of the refund is the difference between the amount of benefits paid by GHI for those expenses and the amount of benefits which should have been paid by GHI for those expenses.

If benefits were paid by GHI for expenses not covered by this Program, GHI will have the right to a refund from you.

### Time limit for starting lawsuits

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

## Appeals

### Appeals: 60-day deadline

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 60 days after you receive notice of denial of the certification or claim to:

ValueOptions
Attn: Customer Service
433 River Street, Suite 200
Troy, New York 12180

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.

Please refer to *"Certification denial and appeal process: deadlines apply"* for information about the appeals process.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, One Commerce Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9am - 5pm Eastern time.

### Your right to an external appeal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### The External Appeal process

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

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

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or GHI. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

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

The External Appeal Agent's decision is binding on both you and GHI. The External Appeal Agent's decision is admissible in any court proceeding.

GHI will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. GHI will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

### 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 Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

### 45-day deadline

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

# EMPIRE BLUECROSS BLUESHIELD
# CERTIFICATE OF INSURANCE
## Empire Plan Prescription Drug Program

*Substitute the following for the CIGNA Certificate of Insurance on pages 131-144 of your Empire Plan Certificate.*

**Certificate of Insurance**

## Section V
## EMPIRE HEALTHCHOICE ASSURANCE, INC.
### doing business as
# EMPIRE BLUECROSS BLUESHIELD
# CERTIFICATE OF INSURANCE
## Empire Plan Prescription Drug Program

Empire HealthChoice Assurance, Inc. (the "Insurer") insures and jointly administers The Empire Plan Prescription Drug Program (the "Program"). CaremarkPCS Health, LLC and its affiliates ("Caremark") is the pharmacy benefit administrator and the Mail Service Pharmacy.

### Meaning of Terms Used

The following terms used in this Certificate with either upper or lower case initial letters shall have the following meanings.

A. **This Program** means The Empire Plan Prescription Drug Program described in this Certificate.

B. The word **you, your,** or **yours** refers to you, the eligible enrollee to whom this Certificate is issued. It also refers to any members of your family who are covered under this Program. For information on eligibility, refer to your *New York State Health Insurance Program General Information Book*.

C. **Pharmacist** means a person who is legally licensed to practice the profession of pharmacy. He or she must regularly practice such profession in a pharmacy.

D. **Pharmacy** means an establishment other than the Mail Service Pharmacy that is registered as a pharmacy with the appropriate state licensing agency or is a Veterans' Affairs medical center or hospital pharmacy, and regularly dispenses medications that require a Prescription from a Doctor. Drugs described in the section *"What Is Covered"* must be regularly dispensed from the Pharmacy by a Pharmacist.

E. **Network Pharmacy** means a Pharmacy, other than the Mail Service Pharmacy, that has entered into a contract with Caremark as an independent contractor to dispense drugs per the terms of the contract.

F. **Non-Network Pharmacy** means any Pharmacy, other than the Mail Service Pharmacy, that has not entered into a contract with Caremark to dispense drugs per the terms of the contract. The Enrollee must file a claim form with the Insurer in order to receive reimbursement for covered drugs received from a Non-Network Pharmacy.

G. **Mail Service Pharmacy** means the specific Mail Service Pharmacy(ies) that has entered into an agreement with Caremark to provide prescription drugs to enrollees through the mail. The Mail Service Pharmacy shall dispense drugs per the terms of this Certificate and in accordance with the laws, rules and regulations that govern pharmacy practice.

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 Policy, and for no other purpose, Doctor also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

I. **Prescription** means the written or oral request for drugs issued by a Doctor duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

J. **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.

**Preferred Brand-Name Drug** means a Brand-Name Drug that has been placed on The Empire Plan Preferred Drug List by the Insurer.

**Non-Preferred Brand-Name Drug** means a Brand-Name Drug that has not been placed on The Empire Plan Preferred Drug List by the Insurer.

K. **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.

L. **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:

1. Some tranquilizers;
2. Stimulants and
3. Pain medications.

M. **Medically Necessary Drug** means any drug that, as determined by the Insurer, is:

1. Provided for the diagnosis or treatment of a medical condition;
2. Appropriate for the symptoms, diagnosis or treatment of a medical condition,
3. Within the standards of generally accepted health care practice; and
4. 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:

- Another Empire Plan carrier 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 carrier 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 pre-authorization 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 Pharmacy proof of payment or pre-authorization of benefits from the other Empire Plan carrier 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 above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

N. **No-Fault Motor Vehicle Plan** means a motor vehicle plan that is required by law. It provides medical or dental care payments, that are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

O. **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.

The information below explains your benefits and responsibilities in detail.

## Your Benefits and Responsibilities

### Copayments

Your prescription drug benefit is based on whether a drug is Generic, Preferred Brand-Name or Non-Preferred Brand-Name. Copayments are based on the drug, the days' supply and whether the Prescription is filled at a Network Pharmacy or the Mail Service Pharmacy.

When you fill your Prescription for up to a **30-day supply at a Network Pharmacy or through the Mail Service Pharmacy,** your copayment is:

- **$5** for a **Generic** Drug
- **$15** for a **Preferred Brand-Name** Drug
- **$30** for a **Non-Preferred Brand-Name** Drug

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

- **$10** for a **Generic** Drug
- **$30** for a **Preferred Brand-Name** Drug
- **$60** for a **Non-Preferred Brand-Name** Drug

When you fill your Prescription for a **31- to 90-day supply through the Mail Service Pharmacy**, your copayment is:

- **$5** for a **Generic** Drug
- **$20** for a **Preferred Brand-Name** Drug
- **$55** for a **Non-Preferred Brand-Name** Drug

One copayment covers up to a 90-day supply. One copayment covers a refill for up to a 90-day supply. Refills are valid for up to one year from the date the Prescription is written.

If the full cost of the drug is less than your copayment, your cost is the lesser amount.

### 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 Brand-Name copayment plus the difference in cost between the Brand-Name and the Generic Drug, not to exceed the full cost of the drug. Otherwise, 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 and Tegretol. For these drugs, you pay only the applicable copayment, which in most cases will be the Non-Preferred Brand-Name copayment.

If your Doctor believes it is medically necessary for you or your family member to have a Brand-Name Drug (that has a generic equivalent), you may appeal the mandatory generic substitution requirement. For an appeal form that you and your Doctor must complete, call toll free 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program. Or, you can write for a generic appeal form to:

The Empire Plan Prescription Drug Program
P.O. Box 11826
Albany, NY 12211

Act promptly. The Insurer will go back only 30 days from the date of receipt of a completed appeals form to adjust claims.

If your appeal is granted and you fill your prescription for the Brand-Name Drug at an Empire Plan Network Pharmacy or through the Mail Service Pharmacy, you pay the Non-Preferred copayment. If your appeal is denied, you can make a second appeal to the Insurer.

### Controlled Drugs

Prescriptions for supplies of Controlled Drugs (drugs classified by Federal or New York State law such as sedatives, sleeping pills, narcotics or pain-control medicines) can be filled through a Network Pharmacy, the Mail Service Pharmacy or a Non-Network Pharmacy.

### Prior authorization required for certain drugs

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for certain medications. If your Doctor prescribes one of these drugs, the Insurer will request from your Doctor the clinical information required to authorize the medication. Your Pharmacy or Doctor may contact the Insurer to begin the authorization process. The Insurer 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. The following is a list of drugs that require prior authorization:

- Amevive
- Aranesp
- Arixtra
- Avonex
- Betaseron
- Botox
- Copaxone
- Enbrel
- Epogen/Procrit
- Flolan
- Forteo
- Fragmin
- Growth Hormones
- Humira
- Immune Globulins
- Increlex
- Infergen
- Innohep
- Intron-A
- Iplex
- Kineret
- Lamisil
- Lovenox
- Myobloc
- Orencia
- Pegasys
- Peg-Intron
- Provigil
- Raptiva
- Rebif
- Remicade
- Remodulin
- Revatio
- Sporanox
- Synagis
- Tracleer
- Tysabri
- Ventavis
- Xolair

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. This list of drugs is subject to change. For the most current list of drugs requiring prior authorization, call The Empire Plan Prescription Drug Program at the number below or go to the New York State Department of Civil Service web site at www.cs.state.ny.us. For more information about drugs requiring prior authorization and how to obtain it, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

If the prior authorization review results in authorization for payment, you will receive Empire Plan Prescription Drug Program benefits for the drug. If the payment is not authorized, no Empire Plan 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 toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program for information on how to initiate an appeal.

### Supply and coverage limits

You can have your prescriptions filled for up to a 90-day supply, with refills for up to one year.

### What is Covered

You are covered for the following prescription drugs or medicines when they are medically necessary and dispensed by a Pharmacy or the Mail Service Pharmacy:

A. Federal Legend Drugs. Drugs or medicines whose labels 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. A compound drug is defined as two or more ingredients (solid, semi-solid or liquid), at least one of which is a covered drug with a valid National Drug Code (NDC) requiring a prescription for dispensing, combined together in a method specified in a prescription issued by a Doctor. The end result of this combination must be a prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer.
**At least one ingredient must be a prescription drug product with a valid NDC.**

**The prescription must identify the multiple ingredients in the compound, including** active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use.

The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA-approved package insert prior to dispensing will not be considered a compound prescription by this Plan.

D. Injectable insulin

E. Oral, injectable or surgically implanted contraceptives that are Federal Legend Drugs, diaphragms and contraceptive devices

F. Vitamins that are Federal Legend Drugs

G. 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.

Please refer to the section *"Exclusions and Limitations"* below for conditions under which benefits for the above are not available.

### Exclusions and Limitations

Charges for the following items are **not** covered expenses:

A. Drugs obtained with no prescription order, except insulin

B. Drugs taken or given at the time and place of the prescription order

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

D. Drugs for which there is no charge or legal obligation to pay in the absence of insurance

E. Drugs administered to you by the facility while a patient in a licensed hospital

This limit applies only if the hospital in which you are a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals; and dispenses such drugs administered to you by the hospital.

F. Any drug refill that is more than the number approved by the Doctor

G. Contraceptive jellies, ointments and foams or devices not requiring a Doctor's order, prescribed for any reason

H. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments or other non-medicinal substances), regardless of their intended use

I. The administration of any Federal Legend Drug or injectable insulin

J. Any drug refill that is dispensed more than one year after the original date of the prescription order

K. 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(l)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 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 U.S. Food and Drug Administration 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"* under Miscellaneous Provisions. 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 non-health care services, the costs of managing research or costs not otherwise covered by The Empire Plan for non-experimental or non-investigational drugs provided in connection with such clinical trial.

L. Immunizing agents, biological sera, blood or blood plasma, except immune globulin

M. Any drug that a Doctor or other health professional is not authorized by his or her license to prescribe

N. 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

O. 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"*.

P. Any drug prescribed and/or dispensed in violation of State or Federal law

Q. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include but are not limited to:

1. Non-amphetamine anorexiants, except for morbid obesity

2. Amphetamines that are prescribed for weight loss, except for morbid obesity
3. Products used to promote hair growth
4. Products (ex. Retinoic Acid) used for prevention of skin wrinkling

R. Any non-medically necessary drugs

IMPORTANT: See your *NYSHIP General Information Book and Empire Plan Certificate* for other conditions that may affect this coverage. See especially the Home Care Advocacy Program (HCAP) section of your UnitedHealthcare Certificate for coverage for prescription drugs billed by a home care agency.

## How to Use Your Empire Plan Prescription Drug Program

When your Doctor prescribes a Medically Necessary Drug covered under The Empire Plan, you can fill the prescription for a supply of up to 90 days and refills for up to one year in one of three ways: at a Network Pharmacy, at a Non-Network Pharmacy or through the Mail Service Pharmacy.

### Network Pharmacies

You can use your Empire Plan Benefit Card for covered prescription drugs at Empire Plan Network Pharmacies. Be sure your Pharmacist knows that you and your family have Empire Plan Prescription Drug Program coverage.

To find a Network Pharmacy, check with your Pharmacist or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

Many retail pharmacies in New York State participate in this Program. Many out-of-State pharmacies participate, as well. All Empire Plan Network Pharmacies can fill Prescriptions for supplies of up to 90 days. Refills are valid for up to a year from the date the Prescription is written. Only one copayment applies for up to a 90-day supply.

### 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. To reduce your out-of-pocket expenses, use your Empire Plan Benefit Card whenever possible.

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.
- 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, which in most cases will be the Non-Preferred copayment.

**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 toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

Mail the completed form with your bills or receipts to:

The Empire Plan Prescription Drug Program
P.O. Box 52071
Phoenix, AZ 85072-2071

### Using the Preferred Drug List

One way you can help control the rapidly increasing cost of prescription drugs is by encouraging your Doctors and Pharmacist to use the preferred list of drugs. (The Empire Plan Preferred Drug List is available at www.cs.state.ny.us.)

This list provides the most commonly prescribed Generic and Brand-Name Drugs included on The Empire Plan Preferred Drug List. These medications 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.

For example one antibiotic can cost $70. Another, equally safe and effective antibiotic used for many of the same conditions, can cost just $10.

The Insurer will provide this preferred list of drugs to you and to Empire Plan participating Doctors. Doctors are encouraged - but not required - to use this list.

Help control the rising cost of the prescription drug program. If your Doctor prescribes a drug on the list, you can be assured of quality drug therapy and cost-effective care.

### Deadline for filing claims

Claims must be submitted within 90 days after the end of the calendar year in which the drugs were purchased, or 90 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

You can order your covered prescription drugs from the Mail Service Pharmacy, and pay by credit card, check or money order.

You can order and receive up to a 90-day supply of your Prescriptions, shipped by first class mail or private carrier. To request mail service envelopes, refills or to speak to a Pharmacist about your mail service Prescription, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program, 24 hours a day, seven days a week.

The Mail Service Pharmacy address is:

Caremark Mail Service
P.O. Box 3223
Wilkes-Barre, PA 18773-3223

## Call The Empire Plan Prescription Drug Program

For questions about your Empire Plan Prescription Drug Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program. The Teletypewriter (TTY) number for callers with a hearing or speech disability is 1-800-863-5488.

**Call 24 hours a day, 7 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 the Mail Service Pharmacy or check order status
- Talk to a customer service representative

- Request prior authorization or a generic appeal
- Talk to a Pharmacist

### Coordination of Benefits

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 dependents is covered under two separate Empire Plan policies, you may submit Empire Plan copayments for reimbursement under your secondary Empire Plan coverage using a paper claim form.

B. **Definitions**

1. **Plan** means a plan that provides benefits or services for or by reason of medical or dental care and that is:
   a. A group insurance plan; or
   b. A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
   c. A self-insured or non-insured plan; or
   d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
   e. A group service plan; or
   f. A group prepayment plan; or
   g. Any other plan that covers people as a group; or
   h. A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
2. **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 paragraph 3. below)
   a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year but:
   b. If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time;
   c. If the other plan does not have the rule described in subparagraphs a. and b. above, 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; and
   d. The word birthday refers only to month and day in a calendar year, not the year in which the person was born.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child;
   c. Finally, the plan of the parent not having custody of the child; and
   d. 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. above determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.

F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.

G. Any information about covered expenses and benefits that is needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.

H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.

I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts that are considered proper under this provision.

### Medicare Prescription Drug Coverage

If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, read the following information about how to use your Empire Plan benefits for secondary coverage.

A Medicare-primary Empire Plan enrollee or dependent enrolled in a Medicare Part D drug plan must use his or her Medicare Part D prescription drug program first. Any amounts not covered by your Medicare Part D plan, such as deductibles, copayments and charges for non-covered drugs, can be submitted to The Empire Plan for consideration using The Empire Plan Prescription Drug Program claim form specifically labeled Medicare Part D Secondary Claim Form. This claim form is available on the New York State Department of Civil Service web site, www.cs.state.ny.us. The form is also available by calling The Empire Plan Prescription Drug Program at 1-877-7-NYSHIP (1-877-769-7447). When you call, be sure to ask for the Medicare Part D claim form.

At retail pharmacies: Any claim submitted to The Empire Plan Prescription Drug Program by a retail pharmacy will be rejected and the Pharmacist will be advised that you have alternate insurance, which is your Medicare Part D drug plan. You are responsible for providing the Pharmacist with the necessary Medicare Part D plan information to submit the claim. Then, you must follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

At the Caremark Mail Service Pharmacy: Any prescription sent to the Caremark Mail Service Pharmacy for a Medicare-primary Empire Plan enrollee or dependent who is also enrolled in a Medicare Part D drug plan will be rejected and returned. You must use your Medicare Part D drug plan first and then follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

IMPORTANT: If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, you must submit your out-of-pocket expenses to The Empire Plan Prescription Drug Program using The Empire Plan Prescription Drug Program Medicare Part D Secondary Claim Form only. Your claim will be processed in accordance with the coordination of benefits provisions of The Empire Plan Prescription Drug Program. If you use the standard Empire Plan Prescription Drug Program claim form, your claim will be rejected and you will have to resubmit it using the Medicare Part D Secondary Claim Form.

## 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 *NYSHIP 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 section of your *NYSHIP 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 *NYSHIP 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 section of your *NYSHIP 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 will be provided on the same basis as if coverage had continued with no change until the day you are no longer Totally Disabled or for three months after the date your coverage ended, whichever is earlier.

Totally Disabled means that because of a sickness or injury you, the enrollee, cannot do your job, or any other work for which you might be trained, or your dependent cannot do his or her usual duties.

### Request for repayment of benefits

The Insurer will seek reimbursement from you for any money paid on behalf of you or your dependents for expenses incurred after loss of eligibility for benefits for any reason. Use of The Empire Plan Benefit Card after eligibility ends constitutes fraud.

### Audits/prescription benefit records

From time to time, the Insurer may ask you to verify receipt of particular drugs from Network Pharmacies or from the Mail Service 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.

### Claims appeal: 60-day deadline

In the event a claim has been denied, in whole or in part, you can request a review of your claim. This request for review should be sent to the Claims Review Unit at the following address within 60 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 questions or comments you deem appropriate.

To request a review of your claim, write to:

The Empire Plan Prescription Drug Program
Complaints and Appeals Unit
P.O. Box 11826
Mail Drop 3H
Albany, NY 12211

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, One Commerce Plaza, Albany, NY 12257. Phone: 1-800-342-3736, Monday - Friday, 9 a.m. – 5 p.m.

### 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 Insurer 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 Insurance to conduct such appeals.

**Your right to appeal a determination that a drug is not medically necessary**

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

A. The prescription drug must otherwise be covered under The Empire Plan Prescription Drug Program; and

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

**Your rights to appeal a determination that a service is experimental or investigational**

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

A. The prescription drug must otherwise be covered under The Empire Plan Prescription Drug Program; and

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

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

Your attending Doctor must also certify that your life-threatening or disabling condition or disease is one for which standard drugs are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard drug or procedure covered by the Program.

In addition, your attending Doctor must have recommended 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 Doctor should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable.)

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

### The External Appeal process

If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the prescription drug is not medically necessary or is an experimental or investigational drug, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Insurer have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Insurer will provide

an external appeal application with the final adverse determination issued through the Insurer's internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

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

If your attending Doctor certifies that a delay in providing the prescription drug that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and the Insurer 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 Insurer's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, the Insurer will provide coverage subject to the other terms and conditions of the Program.

The External Appeal Agent's decision is binding on both you and the Insurer. The External Appeal Agent's decision is admissible in any court proceeding.

The Insurer will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. The Insurer will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

### Your responsibilities in filing an External Appeal

It is **YOUR RESPONSIBILITY** to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. 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.

### 45-day deadline

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

## More About Your Empire Plan Prescription Drug Program

## Drug Utilization Review (DUR)

Prescription drugs can work wonders in curing ailments and keeping you healthy — often at a cost much lower than surgery or other procedures. But they can also cause serious harm when taken in the wrong dosage or in a harmful combination with another drug.

### DUR identifies possible problems

To help avoid problems, your Empire Plan Prescription Drug Program includes a Drug Utilization Review (DUR) program to ensure that your medications are appropriate and your benefit dollars are being spent wisely.

### The DUR process

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 medication?

### When you use your card

When you use your Empire Plan Benefit Card at a Network 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

In addition, a "behind the scenes" safety review is conducted to identify any potential drug therapy related problems. If a potential problem is spotted, 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.

This process is designed to safeguard your health, and it helps your Doctor make more informed decisions about your prescription drugs.

### 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

### For patients

It's 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.

### For doctors

To help your Doctor keep up to date on the most current information on prescription drugs, The Empire Plan has a doctor education program.

# October 1, 2007 Empire Plan Copayments for Contract Affected Employees of New York State in C-82

## Services by Empire Plan Participating Providers

You pay only your copayment when you choose Empire Plan Participating Providers for covered services. Check your directory for Participating Providers in your geographic area, or ask your provider. For Empire Plan Participating Providers in other areas and to check a provider's current status, call UnitedHealthcare at 1-877-7-NYSHIP (1-877-769-7447) toll free or use the Participating Provider Directory on the internet at www.cs.state.ny.us.

Office Visit .....$18

Office Surgery .....$18

(If there are both an Office Visit charge and an Office Surgery charge by a Participating Provider in a single visit, **only one** copayment will apply, in addition to any copayment due for Radiology/Laboratory Tests.)

Radiology, Single or Series;
Diagnostic Laboratory Tests.....$18

(If Outpatient Radiology and Outpatient Diagnostic Laboratory Tests are charged by a Participating Provider during a single visit, **only one** copayment will apply, in addition to any copayment due for Office Visit/Office Surgery.)

Mammography, according to guidelines.....$18

Adult Immunizations.....$18

Allergen Immunotherapy .....No copayment

Well-Child Office Visit, including
Routine Pediatric Immunizations.....No copayment

Prenatal Visits and Six-Week
Check-Up after Delivery .....No copayment

Chemotherapy, Radiation Therapy,
Dialysis.....No copayment

Authorized care at
Infertility Center of Excellence .....No copayment

Hospital-based Cardiac
Rehabilitation Center .....No copayment

Free-standing Cardiac
Rehabilitation Center visit .....$18

Urgent Care Center .....$18

Contraceptive Drugs and Devices when
dispensed in a doctor's office.....$18
(in addition to any copayment(s) due for Office Visit/Office Surgery and Radiology/Laboratory Tests)

Anesthesiology, Radiology, Pathology
in connection with inpatient or
outpatient network hospital services .....No copayment

Ambulatory Surgical Center (including
Anesthesiology and same-day
pre-operative testing done at the center).....$15

Medically appropriate local commercial
ambulance transportation .....$35

## Chiropractic Treatment or Physical Therapy Services by Managed Physical Network (MPN) Providers

You pay only your copayment when you choose MPN network providers for covered services. To find an MPN network provider, ask the provider directly, or call UnitedHealthcare at 1-877-7-NYSHIP (1-877-769-7447) toll free. Internet: www.cs.state.ny.us.

Office Visit .....$18

Radiology; Diagnostic Laboratory Tests .....$18

(If Radiology and Laboratory Tests are charged by an MPN network provider during a single visit, **only one** copayment will apply, in addition to any copayment due for Office Visit.)

## Hospital Outpatient Department Services

Emergency Care.....$60*

(The $50 hospital outpatient copayment covers use of the facility for **Emergency Room Care,** including services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.)

## Network Hospital Outpatient Department Services

Surgery .....$35*

Diagnostic Laboratory Tests .....$35*

Diagnostic Radiology (including
mammography, according
to guidelines).....$35*

Administration of Desferal for
Cooley's Anemia .....$35*

Physical Therapy (following related surgery
or hospitalization) .....$18

Chemotherapy,
Radiation Therapy, Dialysis.....No copayment

Pre-Admission Testing/Pre-Surgical
Testing prior to inpatient admission ...No copayment

***Only one** copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The copayment covers the outpatient facility. Provider services may be billed separately. You will not have to pay the facility copayment 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.

Be sure to follow **Benefits Management Program** requirements for hospital admissions, skilled nursing facility admission and Magnetic Resonance Imaging.

### Mental Health and Substance Abuse Services by Network Providers When You Are Referred by ValueOptions

Call ValueOptions at 1-877-7-NYSHIP (1-877-769-7447) toll free before beginning treatment.

Visit to Outpatient Substance Abuse Treatment Program .....$18

Visit to Mental Health Professional .....$18

Psychiatric Second Opinion when Pre-Certified.....No copayment

Mental Health Crisis Intervention (three visits) .....No copayment

Inpatient .....No copayment

### Empire Plan Prescription Drugs

(**Only one** copayment applies for up to a 90-day supply.)

### Up to a 30-day supply from a participating retail pharmacy or through the Caremark Mail Service Pharmacy

Generic Drug .....$5

Preferred Brand-Name Drug.....$15

Non-Preferred Brand-Name Drug .....$30**

### 31- to 90-day supply from a participating retail pharmacy

Generic Drug .....$10

Preferred Brand-Name Drug.....$30

Non-Preferred Brand-Name Drug .....$60**

### 31- to 90-day supply through the Caremark Mail Service Pharmacy

Generic Drug .....$5

Preferred Brand-Name Drug.....$20

Non-Preferred Brand-Name Drug.....$55**

**If you choose to purchase a brand-name drug that has a generic equivalent, you pay the non-preferred brand-name copayment *plus* the difference in cost between the brand-name drug and its generic equivalent (with some exceptions), not to exceed the full cost of the drug.