MEDICAL POLICY

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Medical Policy Title	**Disability Determination for Extension of Benefits After Coverage Termination**
Policy Number	**10.01.11**
Current Effective Date	**August 20, 2026**
Next Review Date	**August 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. For purposes of determining an individual's eligibility for an extension of benefits due to total disability upon termination of coverage, a Medical Director of the Health Plan will determine whether the individual was totally disabled before and on the date of termination. To request a total disability determination, the treating physician must submit certification of the former member's total disability at the time of termination and must include evidence that the total disability existed prior to the termination.

II. The Health Plan's Medical Director will base his/her disability determination upon the review of the former member's medical records and, if deemed necessary, discussion between the treating physician and the Health Plan's Medical Director or his/her appointed designee. In conducting the review, the Health Plan's Medical Director will be guided by the medical criteria stated in the Disability Evaluation under Social Security (Blue Book), published by the U.S. Social Security Administration.

III. When the Health Plan's Medical Director determines, in his/her sole discretion, that a former member was totally disabled prior to and at the time of termination of coverage, benefits will be provided only for services directly related to the total disability, assuming that the former member is otherwise eligible for an extension of benefits.

RELATED POLICIES

Not Applicable

POLICY GUIDELINE(S)

I. In order to be considered for an extension of benefits due to total disability after termination of coverage, the total disability must have existed prior to termination of the contract.

II. Extensions of benefits differ, depending upon whether a former member loses coverage under a group contract or individual contract and the reason for the loss of coverage. Please refer to the specific paragraph(s) in the Description section below for guidance.

DESCRIPTION

Under the Health Plan's subscriber contracts and certificates, when a member's coverage ends, benefits stop. However, when a Health Plan Medical Director determines that a former member is totally disabled on the date coverage terminates, and that the former member received services or care for the illness, condition, or injury that caused his or her total disability while covered under the subscriber contract, extended benefits may be available as follows.

Group Coverage Termination

I. When an individual who was covered under an insured group contract is determined to be totally disabled as of the date coverage terminates, extended benefits may continue for covered services to treat the total disability, if **ONE** of the following applies:

   A. Termination of employment, eligibility, or contract: When a former member's coverage is terminated due to termination of employment or termination of eligibility, or due to termination of the group contract, extended benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date the coverage ended. The hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy that caused the total disability.

   B. Termination of active employment: Unless coverage is provided for services in connection with the total disability under another health plan, if group coverage providing major medical-type benefits ended because the former member was no longer actively employed, extended benefits will be provided during a period of total disability for at least 12 months from the date coverage ended, but only for covered services to treat the injury, sickness, or pregnancy that caused the total disability.

II. Extended benefits terminate when all the benefits available have been exhausted, when a Health Plan Medical Director or his/her designee determines that the member is no longer totally disabled, or the maximum time period or the extended services have ended. The Health Plan will never provide more benefits than would have been provided, had the member remained covered under the contract.

Individual Coverage Termination

I. When an individual who was covered under an insured individual policy is determined to be totally disabled as of the date coverage terminates, benefits to treat the total disability will extend for 12 months or, if earlier, the end of the total disability.

Please refer to the former member's subscriber contract for the specific benefit extension that may be available to the former member.

SUPPORTIVE LITERATURE

Not Applicable

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

Under the New York State Insurance Regulations, certain benefits are required to be extended for a former Health Plan member who is totally disabled at the time coverage is terminated, but only when all of the requirements are met.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
No specific code(s)	

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HCPCS Codes

Code	Description
No specific code(s)	

ICD10 Codes

Code	Description
No specific code(s)	

REFERENCES

New York State Department of Financial Services. Compilation of Codes, Rules, and Regulations of the State of New York. (11 NYCRR §§ 52.17 (a)(15), 52.18 (b). Rules relating to content of forms for individual and group insurance.

Social Security Administration Office of Disability [internet]. Disability evaluation under Social Security. SSA Pub 64-039. 2008 Sep [accessed 2026 Jun 29]. Available from: https://www.ssa.gov/disability/professionals/bluebook/

SEARCH TERMS

Not applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Extension of benefits for total disability after disenrollment from Medicare is not addressed in National or Regional Medicare coverage determinations or policies.

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

08/26/10, 08/25/11, 08/23/12, 06/27/13, 06/26/14, 06/25/15, 06/22/16, 08/25/17, 08/23/18, 08/22/19, 08/27/20, 08/19/21, 08/18/22, 08/17/23, 08/22/24, 08/21/25, 08/20/26

Date	Summary of Changes
08/20/26	• Annual review, policy intent unchanged.
08/21/25	• Annual review, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
08/26/10	• Original effective date