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TO: New York State Agency Employee Health Benefit Administrators

FROM: Employee Benefits Division (EBD)

SUBJECT: Benefit and Rate Changes for Employees Represented by C-82 Contract Affected and Employees Subject to Binding Arbitration

DATE: March 23, 2010

The State of New York and Council 82 representing Contracted-Affected and Represented (Arbitration Eligible) employees in the Security Supervisors Unit (SSU) have reached an agreement on health insurance related benefits for the period April 1, 2007 through March 31, 2009. This is a summary of benefit changes with effective dates of January 1, 2009 through April 1, 2010, for Employees of the State of New York represented by Council 82 (Except ALESU) and for Contract Affected Employees, enrolled dependents and Cobra enrollees. ALESU title employees will continue to use the January 2010 publications that were mailed to enrollee homes in December 2009. Please pay particular attention when distributing materials to ensure all enrollees receive the proper materials.

Please note these are summaries of the changes and are not intended to provide full information. Empire Plan Reports with full details on these changes are being mailed to enrollees and will be available online shortly.

Rate Change Effective April 1, 2010

As a result of the benefit changes described in this memo, the affected employees will have a rate change effective April 1, 2010. The first checks impacted will be March 25th for employees on Institution payrolls and March 31st for employees on Administration payrolls. Please see Schedule I of HBA Memo NY10-01 (2010 Health Insurance Contribution Biweekly Rates), dated January 1, 2010, for details on the employee share rates for this group effective April 1, 2010.

Empire Plan Medical Benefit Changes

Effective January 1, 2009

Hearing Aid Benefits: The hearing aid benefit for Represented (Employees Subject to Binding Arbitration) will increase to $1,500 benefit once every four years (every two for dependent children age 12 and under, if medically necessary) per hearing aid, per ear. Members who purchased hearing aids on or after January 1, 2009, may have claims reprocessed to allow for the additional $300 benefit by contacting the United Healthcare directly.

Effective January 1, 2010

Coinsurance Annual Maximum: The annual maximum coinsurance out-of-pocket expense under the Basic Medical component will be modified from a single amount for the enrollee and all covered dependents to $800 for the enrollee, $800 for the covered spouse or domestic partner, and $800 for all dependent children combined.

Non-Network Hospital Reimbursement: The maximum reimbursement under the Basic Medical Program for coinsurance paid as the result of using a non-network hospital, skilled nursing facility or hospice under the Hospital Program will be reduced from $1,000 to $500.

Diabetic Shoe Benefit: An annual diabetic shoe benefit will be available through the Home Care Advocacy Program. This network benefit provides for one pair of shoes and multiple inserts with no out-of-pocket cost up to an annual maximum of $500. A non-network benefit is payable under the Basic Medical program, subject to deductible and the remainder to be paid at 75% of the network allowance, up to an annual maximum allowance of $500.

Prosthetic Wigs: Prosthetic wigs shall be a covered basic medical benefit and shall be reimbursed up to a lifetime maximum allowance of $1500, not subject to deductible or coinsurance.

Travel and Lodging: The travel and lodging benefit is no longer subject to a $50,000 lifetime maximum. Travel and lodging benefits will be available as long as the patient remains enrolled and receiving benefits under the COE for Cancer Program.

Effective April 1, 2010

Participating Provider Copayment Increase: The co-payment for office visits, surgical procedures, radiology services, diagnostic/laboratory services, physical therapy, and chiropractic treatment performed by a participating provider will increase to $20.

Outpatient Surgery Center Copayment Increase: The co-payment for covered outpatient surgery performed at participating freestanding outpatient surgical locations that are certified under Article 28 or accredited by one or more of the recognized organizations such as JCAHO (Joint Commission on Accreditation of Healthcare Organizations) will be $30. The co-payment

also covers any radiology and laboratory tests performed on the same day of surgery at the same center.

Expanded Prospective Procedure Review: The current Prospective Procedure Review notification requirement will expand to include pre-notification for MRA, CT, PET and Nuclear Medicine diagnostic procedures, along with MRIs that already require pre-notification, performed at the outpatient department of a hospital, a participating provider office, or a freestanding facility. If an enrollee does not pre-notify UHC before having one of these procedures they will be subject to a payment of the lesser of 50% of the covered hospital or medical charge or $250, plus the enrollee's co-payment, under the participating provider program.

Adult Immunizations: Coverage for adult immunizations for Herpes Zoster (Shingles) will be covered; (for enrollees and dependents age 55 or older) this is a network benefit with a co-payment, and is subject to established medical protocols.

Diabetes Education Centers: UHC will recruit into the Empire Plan participating provider network Diabetes Education Centers accredited by the American Diabetes Education Recognition Program. Enrollees will be subject to an office visit co-payment for each visit to a participating Diabetes Education center. There is also a non-network benefit subject to annual deductible and coinsurance**.**

Chronic Kidney Disease Management Program: The Empire Plan will offer a Kidney Resource Service Program to Empire Plan primary individuals. Enrollees or dependents that have been diagnosed with Chronic Kidney Disease will be invited by United Healthcare to participate in this disease management program.

Travel and Lodging Reimbursement for Cancer Centers of Excellence and Transplant Centers of Excellence: The meals and lodging reimbursement available to enrollees living more than 100 miles from the Center of Excellence and a traveling companion will be based on the federal government's standard reimbursement rates for one or two people, which can be located at www.gsa.gov. Only one lodging reimbursement per day will be allowed. The following are the only additional travel expenses that are reimbursable: meals, auto mileage (personal or rental car) reimbursed at standard IRS defined rate, economy class airfare (when the patient lives 200 or more miles from the COE), train fare, taxi fare, parking, tolls, shuttle or bus fare from lodging to COE.

HCAP Durable Medical Equipment: Certificate of Coverage language and benefits under the Home Care Advocacy Program for the purchase of Durable Medical Equipment shall be modified as follows:

- Benefits are provided for a single unit of equipment and repair or replacement as necessary.

Effective January 1, 2012

The Basic Medical Provider Discount Program will expire on December 31, 2011.

Empire Plan Hospital/Medical Benefit Changes

Effective January 1, 2010

Non-Network Hospital Reimbursement: The maximum reimbursement under the Basic Medical Program for coinsurance paid as the result of using a non-network hospital, skilled nursing facility or hospice under the Hospital Program will be reduced from $1,000 to $500.

Empire Plan Hospital Benefit Changes

Effective April 1, 2010

Emergency Room Copayment – The copayment for emergency room services will increase to $60 for Arbitration Eligible employees. Contract Affected employees already pay a $60 copayment.

Empire Plan Managed Mental Health & Substance Abuse Treatment Benefit Changes

Effective January 1, 2010

Out of Pocket Maximum: The annual maximum coinsurance out-of-pocket expense under the Basic Medical component will be modified from a single amount for the enrollee and all covered dependents to $800 for the enrollee, $800 for the covered spouse or domestic partner, and $800 for all dependent children combined.

Coinsurance Maximum for Non-Network Mental Health Facility Services: The enrollee is responsible for the first $500 of coinsurance, and all coinsurance amounts in excess of $1,000 up to $1,500. Coinsurance amounts between $500 and $1,000 will be refunded upon written request. The coinsurance maximum applies separately to the enrollee, spouse/domestic partner, and/or all children and is calculated on an annual basis.

Non-Network Hospital Reimbursement: The maximum reimbursement under the Basic Medical Program for coinsurance paid as the result of using a non-network hospital, skilled nursing facility or hospice under the Hospital Program will be reduced from $1,000 to $500.

Effective April 1, 2010

Substance Abuse Co-Payment: Each visit for network outpatient substance abuse care will be subject to a $20 co-payment.

Mental Health Co-Payment: Each visit to a network practitioner for outpatient mental health care will be subject to a $20 co-payment.

Disease Management Programs: Disease management programs will be expanded to include Attention Deficit Hyperactivity Disorder and Eating Disorders including appropriate nutritional services will be implemented.

Empire Plan Prescription Drug Benefit Changes

Effective April 1, 2010

Co-payments: The co-payments for non-preferred prescription drugs purchased at a network retail pharmacy or the mail service pharmacy shall increase as follows:

- The co-payment for up to a 30-day supply of a non-preferred prescription drug purchased at a network retail pharmacy, or through Medco Pharmacy (mail service), will increase from $30 to $40.
- The co-payment for a 31-90 day supply of a non-preferred prescription drug purchased at a network retail pharmacy will increase from $60 to $70.
- The co-payment for a 31-90 day supply of a non-preferred prescription drug purchased at the mail service pharmacy will increase from $55 to $65.

The Empire Plan Flexible Formulary will be implemented. As a result of the change to the Flexible Formulary, enrollees may see some differences in coverage and/or preferred status of drugs. Additionally, some prescription drugs will be excluded from coverage. The goal of the Flexible Formulary is to provide enrollees and the Plan with the best value in prescription drug spending. The current Flexible Formulary is available on NYSHIP Online and includes a list of excluded drugs. All enrollees who are taking prescription drugs that become non-preferred or excluded from coverage effective April 1, 2010 will receive a letter notifying them of the change and providing them with potential preferred drug alternatives to discuss with their physician.

The Empire Plan Specialty Pharmacy Program will be implemented. The Program will consist of a network of one or more specialty pharmacies.

Eligibility Changes

Effective April 1, 2010 (Empire Plan and HMO enrollees)

Dependent Student Eligibility: Covered dependent students shall be provided with a three month extended benefit period upon completion of each semester as a covered full-time student (or equivalent). Consequently, unmarried dependent children who are 19 or over but under age 25 are eligible if they are **full-time** students at an accredited secondary or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage. They continue to be eligible until the first of these events occur:

- The end of the third month following the month in which the dependent completes a semester; or
- The end of the month in which attendance at school ends if the semester is not completed and proof of the last day of attendance for the semester is provided, or the end of the third month following the month that the last semester was completed, whichever is later; or
- The starting date of the semester if the semester is not completed and no proof of attendance is provided, or the end of the third month following the month that the last semester was completed, whichever is later.

Workers' Compensation Due to Assault: A permanent full-time employee who is removed from the payroll due to an assault, as described in Article 14.9, and is granted workers' compensation for up to 24 months shall remain covered under the State Health Insurance Plan for the same duration and will be responsible for the employee share of premium.