New York State
Health Insurance Program

General Information Book and Empire Plan Certificate

Certificate Amendments

For Employees of the State of New York

designated Management/Confidential; Legislature;
and for their enrolled Dependents
and for COBRA enrollees with their Empire Plan benefits

April 2000

State of New York
Department of Civil Service
Employee Benefits Division

Keep this booklet with your January 1, 1996 *New York State Health Insurance Program General Information Book and Empire Plan Certificate*. Pages in your Book/Certificate and later Book sections issued with *Empire Plan Reports* have consecutive numbers.

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The policies and benefits described in this booklet are established by the State of New York through negotiations with State employee unions and administratively for 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 January 1, 1996 *NYSHIP General Information Book and Empire Plan Certificate* and later Amendments included in *Empire Plan Reports*, this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Substitute the following for the last sentence in the second paragraph under "Eligibility for retiree coverage" in the "Continuing Coverage When You Retire or Vest" section on page 16 of your NYSHIP General Information Book.

Retiree coverage

Do not assume that you are eligible for health insurance benefits in retirement. Also, if you are eligible but do not want your coverage to continue when you retire, you must contact your agency Health Benefits Administrator.

Substitute the following for the fifth paragraph under "Lifetime monthly credit" in the "Continuing Coverage When You Retire" section on page 18 of your NYSHIP General Information Book.

Sick Leave Credit

When you retire, if the dollar value of your sick leave amounts to $100 or less, it will be calculated in the same manner as dollar values of $100 or more to provide a lifetime monthly amount of no less than $.01 per month. Or, you may choose to have a credit of less than $100 applied to monthly premiums until the amount runs out. Then, you will contribute the usual enrollee share. Before you retire, you must notify the Employee Benefits Division in writing if you want to use this run-out sick leave method.

Substitute the following for the third paragraph under "Deferred Health Insurance Coverage" in the "Continuing Coverage When You Retire or Vest" section on page 19 of your NYSHIP General Information Book.

Deferred Health Insurance Coverage

If you die while you are in deferred coverage status, your spouse and any eligible dependents must write to the Employee Benefits Division within 90 days. Eligibility requirements for your spouse and eligible dependents to transfer back to NYSHIP are the same as if you had continued your coverage into retirement.

If you choose Dual Annuitant sick leave credit at the time of retirement and die while in deferred status, your eligible surviving spouse will retain the 70 percent sick leave credit. The amount will be calculated based on your age at the time of death.

Substitute the following for "Choice of option" in the "COBRA: Continuation of Coverage" section on page 24 of your NYSHIP General Information Book as amended in your November 1996 Empire Plan Report.

COBRA: Choice of option and coverage

An employee, spouse/domestic partner or dependent child who continues coverage under COBRA will continue in the same plan in which you are enrolled. A COBRA enrollee may change to a different option during the annual Option Transfer Period or when moving under the circumstances described on page 2.

When two or more persons (enrollee, spouse/domestic partner, children) covered under the same Family contract seek COBRA coverage as a result

of the same qualifying event, they must continue Family coverage; they may not elect Individual COBRA coverages, unless both spouses/domestic partners are State employees, until the next Option Transfer Period. Beginning with the Option Transfer Period in 2000, and in each subsequent Option Transfer Period, each COBRA beneficiary may elect to change to Individual coverage in a different plan from that of the family unit.

Add the following to the first paragraph under "60-day deadline" in the "COBRA: Continuation of Coverage" section on page 25 of your NYSHIP General Information Book.

60-day deadline to apply for COBRA

Other people acting on your behalf may provide written notice to the Employee Benefits Division of a COBRA-qualifying event.

Substitute the following for the second paragraph under "60-day deadline" in the "COBRA: Continuation of Coverage" section on page 25 of your NYSHIP General Information Book.

If the Employee Benefits Division does not receive notice in writing within that 60-day period, regardless of the reason, the enrollee or dependent will not be entitled to choose continuation coverage. Your employing agency is responsible for notifying the Employee Benefits Division of a reduction in your hours or termination of your employment.

Substitute the following for the fifth paragraph under "60-day deadline" in the "COBRA: Continuation of Coverage" section on page 25 of your NYSHIP General Information Book.

If you or your eligible dependent, or someone else acting on your behalf, does not choose continuation coverage, NYSHIP insurance coverage will end.

Add the following sentence at the end of "Your costs under COBRA" in the "COBRA: Continuation of Coverage" section on page 25 of your NYSHIP General Information Book.

COBRA payment

Payment is considered made on the date of the postmark.

Conversion

Delete "Conversion: Mental health and substance abuse coverage" in the "Changing from NYSHIP to Direct-Pay Conversion Contracts" section on page 27 of your NYSHIP General Information Book as amended in your July 1999 Empire Plan Report.

Substitute the following for "Conversion: Prescription drug coverage" in the "Changing from NYSHIP to Direct-pay Conversion Contracts" section on page 27 of your NYSHIP General Information Book as amended in your July 1999 Empire Plan Report.

Conversion: Prescription drug coverage

Prescription drug coverage is provided under the Blue Cross conversion policy.

Substitute the following for "How to request direct-pay conversion contracts" in the "Changing from NYSHIP to Direct-Pay Conversion Contracts" section on page 27 of your NYSHIP General Information Book as amended in your July 1999 Empire Plan Reports.

How to request direct-pay conversion contracts

Blue Cross: To request a conversion policy, dependents should call or write to: Empire Blue Cross and Blue Shield, P.O. Box 11800, Albany, New York 12211-0800; 518-367-0025; 1-800-261-5962.

United HealthCare: To request a conversion policy for medical/surgical coverage, write to: United HealthCare, P.O. Box 1600, Kingston, New York 12402-1600.

1-800-992-1213 to pre-certify skilled nursing facility admission

Insert the following after the fourth paragraph under "Pre-Admission Certification" on page 36 of your Benefits Management Program Certificate.

You must call the Benefits Management Program for certification before admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility.

If you do not call for skilled nursing facility admission

Insert the following at the end of "Pre-Admission Certification" in the "Benefits and Your Responsibilities" section on page 36 of your Benefits Management Program Certificate.

Effective January 1, 2000. You must call the Empire Plan Benefits Management Program at 1-800-992-1213 for pre-certification before admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility. By calling prior to admission, you will know whether your care in a skilled nursing facility meets the criteria for Empire Plan benefits. Also, if your stay is pre-certified, you, your doctor and the facility will be notified in writing no later than the day before your certification for skilled nursing facility care will end.

If you do not call for pre-admission certification of a medically necessary covered admission to a skilled nursing facility including transfer from a hospital to a skilled nursing facility, you will be required to pay a $200 deductible.

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

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

If the above conditions are not met, skilled nursing facility care is not covered under the Empire Plan.

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

Substitute the following for the third paragraph of "Your call will start the review process" under "4. Prospective Procedure Review: MRI" in the "Benefits and Your Responsibilities" section on page 37 of your Benefits Management Program Certificate as amended in your May 1996 Empire Plan Report.

Emergency MRI

You do not have to call the Benefits Management Program before an emergency MRI. When Blue Cross or United HealthCare receives the claim for the MRI, Blue Cross or United HealthCare will determine whether the MRI was performed on an emergency basis and whether the MRI was medically necessary.

Substitute the following for the section "There are penalties for not complying with the Prospective Procedure Review requirements" under "4. Prospective Procedure Review: MRI" in the "Benefits and Your Responsibilities" section on page 37 of your Benefits Management Program Certificate as amended in your May 1996 Empire Plan Report.

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

If you fail to call the Empire Plan's Benefits Management Program, Blue Cross and/or United HealthCare will conduct a medical necessity review. If the review does not confirm that the MRI was medically necessary, you will be responsible for the full charges. No benefits will be paid under your Empire Plan coverage. If you fail to call the Benefits Management Program and the Blue Cross and/or United HealthCare 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 $25 hospital outpatient copayment.
- When the provider(s) administering and/or interpreting the MRI is an Empire Plan participating provider, 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 $8 copayment.
- When the provider(s) administering and/or interpreting the MRI is not an Empire Plan participating provider, you are liable for the lesser of 50 percent of the reasonable and customary charges or $250. In addition, you must meet your Basic Medical annual deductible and you must pay the coinsurance and any provider charges above the reasonable and customary amount. (The coinsurance is the 20 percent you pay for covered services by non-participating providers, up to an annual maximum.)

BLUE CROSS® CERTIFICATE OF INSURANCE

Substitute the following for the first paragraph under "You must call ..." in the "Benefits Management Program" section on page 42 of your Blue Cross Certificate.

You must call the Benefits Management Program

All of the inpatient hospital and skilled nursing facility benefits provided by Blue Cross under the Empire Plan are subject to the provisions of the Empire Plan's hospital and medical Benefits Management Program. Please read about the Benefits Management Program requirements in the preceding section of this book.

Insert the following before "Emergency Admission" in the Benefits Management Program section on page 42 of your Blue Cross Certificate.

Blue Cross coverage when you do not call the Benefits Management Program for skilled nursing facility admission or outpatient MRI

Effective January 1, 2000. If you do not follow the provisions of the Benefits Management Program, Blue Cross 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 a medically necessary covered admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility, Blue Cross will apply a $200 deductible. If your care is not certified as medically necessary, you will be responsible for the full charges. No benefits will be paid under your Blue Cross coverage.
- If you did not follow the Prospective Procedure Review requirements for an elective (scheduled) Magnetic Resonance Imaging (MRI), and the procedure was performed in the outpatient department of a hospital, Blue Cross will conduct a medical necessity review. If the review does

not confirm that the procedure was medically necessary, you will be responsible for the full charges. No benefits will be paid under your Blue Cross coverage. If you fail to call the Benefits Management Program and the Blue Cross 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. You will also be responsible for your $25 hospital outpatient copayment.

Insert the following after the "Benefits Management Program" section on page 42 of your Blue Cross Certificate.

Infertility Benefit Coverage

Empire Plan benefits for infertility are as stated under the Infertility Benefits provision included in the United HealthCare Certificate. Any hospital inpatient and/or outpatient expenses incurred for Qualified Procedures under the Infertility Benefit and payable under the Blue Cross Certificate will be applied toward the $25,000 lifetime maximum per covered person.

Blue Cross will not pay any benefits where prior authorizations have not been obtained for Qualified Procedures as required by the Infertility Benefits included in the United HealthCare Certificate.

Add the following at the end of "6. Physical therapy" in the "Outpatient Hospital Care" section on page 44 of your Blue Cross Certificate.

Outpatient physical therapy: $8 Copay

Effective January 1, 2000. You pay an $8 copayment for each visit to the outpatient department of a hospital for physical therapy when covered by Blue Cross.

Substitute the following for "8. Intravenous Chemotherapy" in the "Outpatient Hospital Care" section on page 44 of your Blue Cross Certificate.

Outpatient chemotherapy

8. **Chemotherapy.** Blue Cross pays for chemotherapy. The treatment must be ordered by your doctor. Intravenous chemotherapy, oral chemotherapy, subcutaneous injections and intramuscular injections are covered by Blue Cross only if the outpatient hospital setting is medically necessary.

Substitute the following for the first bulleted section of "copayment for outpatient hospital services" on page 45 of your Blue Cross Certificate as amended in your December 1998 Empire Plan Report.

Emergency care: $35 copayment

- Emergency care (see page 44).

  Effective January 1, 2000. The copayment for emergency care is $35. The $35 copayment covers use of the hospital outpatient department 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 United HealthCare Certificate, pages 69-70, if you receive bills for hospital emergency room services from these providers.

Substitute the following for the last paragraph under "copayment for outpatient hospital services" in the "Outpatient Hospital Care" section on page 45 of your Blue Cross Certificate.

Outpatient hospital services

There is no copayment for the following covered hospital outpatient services:

- Chemotherapy
- Radiation therapy
- Dialysis

Substitute the following for the third paragraph in 1. A. and for paragraph 1. B. in the Skilled Nursing Facility Care section on page 46 of your Blue Cross Certificate.

You must call the Benefits Management Program before admission to a skilled nursing facility

The Benefits Management Program requirement to call for pre-admission certification applies to skilled nursing facility admission, including transfer from a hospital to a skilled nursing facility.

B. Coverage will only be provided for as long as inpatient hospital care would have been required if care in a skilled nursing facility were not provided. If your care is pre-certified, you, your doctor and the facility will be notified no later than the day before your certification for skilled nursing facility care will cease.

Add the following at the end of "2. Care must be medically necessary" under "Limitations and Exclusions" in the "Blue Cross General Provisions" section on page 48 of your Blue Cross Certificate.

General Provisions

However, if an External Appeal Agent, in accordance with the external appeal provisions under **Filing an Appeal** on page 57, overturns Blue Cross' determination that care was medically unnecessary, then Blue Cross will cover the hospitalization or related expense to the extent that the hospitalization or related expense is otherwise covered under this Certificate.

Add the following at the end of "12. Experimental/Investigative procedures" under "Limitations and Exclusions" in the "Blue Cross General Provisions" section on page 49 of your Blue Cross Certificate as amended in your March 1998 Empire Plan Report.

Experimental/ investigational procedures

Experimental/Investigational procedures shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under **Filing an Appeal** on page 57. If the External Appeal Agent approves coverage of an Experimental or Investigational procedure, only the costs of services required to provide the procedure to you according to the design of the clinical trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

Substitute the following for the first bullet under "2." in the "Filing and Payment of Blue Cross Claims" section on page 55 of your Blue Cross Certificate.

Filing and payment of claims

If the hospital does not deal directly with its local Blue Cross Plan:

- For services in the United States, except within New York State, the bill is payable to the hospital unless you have already paid the bill. Then Blue Cross will pay you directly.

Substitute the following for the last sentence of the second paragraph of the third bullet of "2." in the "Filing and Payment of Blue Cross Claims" section on page 56 of your Blue Cross Certificate.

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

Add the following at the end of "Filing and Payment of Blue Cross Claims" on page 56 of your Blue Cross Certificate.

Denial of claim

3. **If Blue Cross denies your claim for benefits.** If Blue Cross denies your claim for benefits for a medical procedure or service on the basis that the medical procedure or service is not medically necessary, benefits will be paid by Blue Cross for covered hospitalization and related expenses if:

- Another Empire Plan carrier has liability for some portion of the expenses for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service; or
- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written pre-authorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the pre-authorization; and
- You provide to Blue Cross proof of payment or pre-authorization of benefits from the other Empire Plan carrier regarding the availability of Empire Plan benefits to you for that medical procedure or service.

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

Add the following at the end of the "Filing an Appeal" section on page 57 of your Blue Cross Certificate as amended in your March 1999 Empire Plan Report.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Blue Cross 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 to 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 Certificate; and

B. You must have received a final adverse determination through the internal appeal process described above and Blue Cross must have upheld the denial **or** you and Blue Cross 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 Certificate; and

B. You must have received a final adverse determination through the internal appeal process described above and Blue Cross must have upheld the denial **or** you and Blue Cross 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 Blue Cross 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. Blue Cross will provide an external appeal application with the final adverse determination issued through Blue Cross' 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 Blue Cross based its denial, the External Appeal Agent will share this information with Blue Cross in order for it to exercise its right to reconsider its decision. If Blue Cross chooses to exercise this right, Blue Cross will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Blue Cross 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 Blue Cross. 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 Blue Cross 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 Blue Cross' decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, Blue Cross will provide coverage subject to the other terms and conditions of the Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Blue Cross will only cover the costs of services required to provide treatment to you according to the design of the trial. Blue Cross 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 Certificate for non-experimental or non-investigational treatments provided in such clinical trial.

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

Blue Cross 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. Blue Cross will 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 for External Appeal

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 Blue Cross that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. Blue Cross has no authority to grant an extension of this deadline.

Substitute the following for the first paragraph under "Where to Get More Detailed Information" on page 58 of your Blue Cross Certificate. Also delete the list of local Blue Cross Plans and the counties they serve.

Where to Get More Detailed Information

If this book does not answer the questions you may have about your Blue Cross coverage, contact the Employee Benefits Division in the Department of Civil Service or:

Empire Blue Cross and Blue Shield
New York State Service Center
Box 11815
Albany, New York 12211-0815

518-367-0009 Albany area and Alaska; 1-800-342-9815 New York State and other states except Alaska

TTY (Text Telephone) for hearing-impaired or speech-impaired callers: 1-800-241-6894

CERTIFICATE AMENDMENT
for
The Empire Plan

- **THIS CERTIFICATE AMENDMENT AFFECTS YOUR RIGHTS AS AN ELIGIBLE ENROLLEE UNDER THE EMPIRE PLAN. PLEASE READ IT CAREFULLY.**
- **THIS IS TO NOTIFY YOU THAT THE EMPIRE PLAN MEDICAL BENEFITS INSURANCE OBLIGATIONS OF METROPOLITAN LIFE INSURANCE COMPANY, UNDER THE GROUP POLICIES LISTED BELOW, SHALL ON AND AFTER JANUARY 1, 2000 BE TRANSFERRED TO UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK.**
- **THIS CERTIFICATE AMENDMENT IS ISSUED TO YOU BY UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK. IT IS TO BE ATTACHED TO AND WILL FORM A PART OF YOUR GENERAL INFORMATION BOOK AND EMPIRE PLAN CERTIFICATE.**

Group Insurance Policy Numbers: 30500-G, 30501-G and 30502-G, all three collectively referred as the "Group Policies".

Policyholder of the Group Policies: State of New York.

Transfer of Obligations: Effective January 1, 2000, the medical insurance benefits obligations of Metropolitan Life Insurance Company under the Group Policies and all Certificates issued under the Group Policies are transferred to United HealthCare Insurance Company of New York ("United HealthCare"). United HealthCare agrees to pay each eligible enrollee in the Empire Plan the medical insurance benefits described in the Certificates, subject to the provisions and conditions contained in the Certificates.

Name of Insurer: Effective January 1, 2000, if any reference is made in any Certificates to Metropolitan Life Insurance Company (including "Metropolitan" or "MetLife" or any other reference) the reference shall mean "United HealthCare Insurance Company of New York."

Insurers' Address: The addresses of the corporate headquarters for the former and succeeding insurers are respectively:

Former Insurer:

Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010

Insurer on and after January 1, 2000:

United HealthCare Insurance Company of New York
2929 Expressway Drive North, Suite 300
Hauppauge, New York 11788

This Certificate Amendment is effective January 1, 2000.

METROPOLITAN LIFE INSURANCE COMPANY

By: [signature]

Name: Craig J. Guiffre

Title: Vice-President

Date: 2/7/00

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

By: M. Laurie Wasserstein

Name: M. Laurie Wasserstein

Title: Vice President

Date: 2-4-00

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Add the following at the end of "Meaning of Terms Used" on page 64 of your United HealthCare Certificate.

Urgent Care Center

AA. An Urgent Care Center is a facility staffed by medical professionals that include physicians and nurses, with evening and weekend hours. It provides services for acute and uncomplicated problems without the need for appointment.

Substitute the following for the second and third paragraphs under "... when you choose participating providers" in the "Participating Provider Program" section on page 64 of your United HealthCare Certificate.

You pay only your $8 copayment for office visits, surgical procedures performed during an office visit, radiology services, diagnostic laboratory services and visits to an urgent care center when they are covered under the Participating Provider Program. You pay only your $15 copayment for facility charges, including anesthesiology, at a participating ambulatory surgical center. There is no cost to you for some services covered under the Participating Provider Program.

To learn whether a doctor, specialist, laboratory, ambulatory surgical center or urgent care center is an Empire Plan participating provider, check with the provider directly or call United HealthCare at 1-800-942-4640. Or, visit the New York State Department of Civil Service Web site at http://www.cs.state.ny.us. Click on Employee Benefits and Services, then on Empire Plan Participating Provider Directory and follow the instructions.

Substitute the following for the second sentence of the fifth paragraph under "... when you choose participating providers" under "Participating Provider Program" on page 65 of your United HealthCare Certificate.

The Empire Plan does not require that a participating provider refer you to a participating specialist, laboratory, ambulatory surgical center or urgent care center.

Add the following at the end of "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 66 of your United HealthCare Certificate.

Q. **Urgent Care Center** - You are covered for medically necessary visits to and services provided at an Urgent Care Center.

Add the following at the end of "What is covered under the Basic Medical Program (non-participating providers)" in the "Basic Medical Program" section on page 70 of your United HealthCare Certificate.

T. **Urgent Care Center** - You are covered for medically necessary visits to and services provided at an Urgent Care Center.

Substitute the following for the last sentence in "D. Participating Providers" under "Meaning of Terms Used" on page 62 of your United HealthCare Certificate.

Centers of Excellence for Infertility Treatment

Exceptions to payment-in-full under the Participating Provider Program are detailed in the Benefits Management Program section and under Infertility Treatment benefit.

Add at the end of "P. covered percentage" under "Meaning of Terms Used" on page 64 of your United HealthCare Certificate.

For Infertility Benefits, expenses are paid the same as for other medical conditions. The covered percentage for non-network services is 80 percent of the reasonable charges. The covered percentage becomes 100 percent of scheduled allowances after your copayments for network services. However,

you have no copayment at an Infertility Center of Excellence. Certain benefits are subject to a lifetime maximum as indicated in the section titled Infertility Benefits.

Add the following at the end of "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 66 of your United HealthCare Certificate.

Adult Immunizations

R. **Adult Immunizations - Effective January 1, 2000.** You pay an $8 copayment for influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chicken pox) and tetanus immunizations.

Infertility Treatment: Participating Provider Program

S. **Infertility Treatment - Effective January 1, 2000.** See page 163 for information regarding benefits for the treatment of infertility.

Substitute the following for "H" under "What is covered under the Basic Medical Program (non-participating providers)" in the "Basic Medical Program" section on page 69 of your United HealthCare Certificate.

Newborn child care

H. **Routine Newborn Child Care – Effective January 1, 2000.** Doctors' services for the routine care of a newborn child are covered up to a total maximum payment of $150. *These benefits are not subject to deductible or coinsurance.*

Add at the end of "A. Hospitals" on page 68 in the "Basic Medical Program" section of your United HealthCare Certificate.

Infertility Treatment: Basic Medical Program

United HealthCare will provide coverage for services and supplies in connection with Infertility Benefits whether or not benefits are available under the Empire Plan's hospital benefits plan.

Add the following at the end of "What is covered under the Basic Medical Program (non-participating providers)" in the "Basic Medical Program" section on page 69 of your United HealthCare Certificate.

U. **Infertility Treatment - Effective January 1, 2000.** See page 163 for information regarding benefits for the treatment of infertility.

Add the following at the end of the first paragraph under "Pre-Admission Certification" in the "Benefits Management Program" section on page 70 of your United HealthCare Certificate.

Pre-Admission Certification

You must call the Benefits Management Program at 1-800-992-1213 for Pre-Admission Certification before admission to a skilled nursing facility including transfer from a hospital to a skilled nursing facility.

Substitute the following for the second paragraph under "Pre-Admission Certification" in the "Benefits Management Program" section on page 70 of your United HealthCare Certificate.

If you do not comply with Pre-Admission Certification requirements for hospital admission, you will be subject to paying a $200 hospital deductible and a $100 copayment for each day it is determined that your hospitalization is not medically necessary. If you do not comply with Pre-Admission requirements for admission or transfer to a skilled nursing facility, you will be required to pay a $200 deductible.

HCAP Network Coverage: Paid-in-full benefit

Delete "Nursing Services" and "I. Durable Medical Equipment" under "What is covered under the Basic Medical Program (non-participating providers)" on pages 68 and 69 and substitute the following for the third paragraph of the Home Care Advocacy Program section on page 71 of your United HealthCare Certificate.

You must call 1-800-638-9918 even if Medicare is primary

You must call 1-800-638-9918 to arrange for services and you must use an HCAP-approved provider to receive paid-in-full benefits under Network coverage. You must call HCAP even if Medicare or another plan is primary. Effective January 1, 2000, if you do not call HCAP before receiving services, you will receive the non-network level of benefits for medically necessary covered services. The following home care services and/or durable medical equipment or supplies are covered under HCAP when prescribed by your doctor and determined to be medically necessary by United HealthCare.

Substitute the following for the third paragraph in "2. Home Nursing Services" in the "Home Care Advocacy Program" section on page 71 of your United HealthCare Certificate.

Home Nursing Services

Refer to Non-network benefits for coverage of nursing services when you do not use HCAP.

Substitute the following for "If you call HCAP but do not use an HCAP provider" and for "If you do not call HCAP" in the "Home Care Advocacy Program" section on pages 72-73 of your United HealthCare Certificate.

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

You will receive Non-network benefits if:

1. You do not call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies; *or*
2. You call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies; *and* United HealthCare precertifies your home care and/or equipment or supplies as medically necessary; but you use a non-participating provider that HCAP has not approved for covered services and/or equipment or supplies.

Non-network benefits

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

48 hour exclusion for nursing care: You are responsible for the cost of the first 48 hours of nursing care per calendar year. This is not a covered expense and will not be applied toward your Basic Medical Program annual deductible.

Basic Medical Program annual deductible applies: You must satisfy your Basic Medical Program annual deductible before non-network benefits will be paid for HCAP covered services, equipment or supplies. The amount applied toward satisfaction of the Basic Medical Program annual deductible for non-network HCAP covered services, equipment and supplies will be the lower of the following:

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

Non-network Benefits: After you have satisfied your Basic Medical Program annual deductible, submit a claim to United HealthCare. You will be reimbursed for medically necessary HCAP covered home care services, durable medical equipment or supplies up to a maximum of 50 percent of the network allowance. You are responsible for any amounts in excess of 50 percent of the network allowance; the **Basic Medical Coinsurance Maximum does not apply.** No expenses you pay in excess of the non-

network benefit may be applied to your annual coinsurance maximum for the Basic Medical Program.

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

Insert the following after the Managed Physical Medicine Program on page 75 of your United HealthCare Certificate.

Infertility Benefits

Effective January 1, 2000. You have the following benefits for the treatment of infertility.

For the purposes of this benefit, infertility is defined as a condition of an individual who is unable to achieve a pregnancy because the individual and/or partner has been diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but has been unable to carry a fetus to full term. Infertility benefits under the Empire Plan are payable whether you use participating or non-participating providers.

What is Covered

The following Covered Services and Supplies 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. As for any other medical condition, the benefit maximum is unlimited for these expenses. By using participating providers, you minimize your out-of-pocket costs.

Covered Services and Supplies:

- Patient Education/Program Orientation
- Diagnostic Testing
- Ovulation Induction/Hormonal Therapy
- Surgery to enhance reproductive capability

1-800-638-9918 for prior authorization for Qualified Procedures

Certain procedures, called Qualified Procedures, are covered under the Infertility Benefit only if you call United HealthCare in advance at 1-800-638-9918 and receive prior authorization. Qualified Procedures are specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility. If United HealthCare authorizes benefits, the following Qualified Procedures are covered:

- Artificial insemination
- Assisted Reproductive Technology (ART) procedures including:
  - In vitro fertilization and embryo placement
  - Gamete Intra-Fallopian Transfer (GIFT)
  - Zygote Intra-Fallopian Transfer (ZIFT)
  - Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility
  - Assisted hatching
  - Microsurgical sperm aspiration and extraction procedures, including:
    - Microsurgical Epididymal Sperm Aspiration (MESA), and
    - Testicular Sperm Extraction (TESE)
- Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (that is, freezing and storage of sperm, eggs or embryos) for up to 6 months.

Participating Provider and Basic Medical Programs

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 but are subject to the lifetime maximum stated in this benefit. By using participating providers, you minimize your out-of-pocket costs. Qualified Procedures are not payable if: 1) you fail to call prior to receiving any Qualified Procedures or 2) the benefits are not authorized by United HealthCare.

Infertility Centers of Excellence

Centers of Excellence

Infertility Centers of Excellence are a select group of participating providers recognized by United HealthCare as leaders in reproductive medical technology and infertility procedures and contracted by United HealthCare to be Infertility Centers of Excellence. These centers are available to provide to you the listed Covered Services and Supplies and Qualified Procedures. If you are authorized to receive Qualified Procedures, the infertility benefit offers you the choice to receive care at an Infertility Center of Excellence. Expenses for benefits provided at an Infertility Center of Excellence are payable in full, subject to the maximum lifetime benefit. No copayments will be applied.

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 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.

Maximum lifetime benefit

Certain expenses for infertility are subject to a lifetime maximum of $25,000 per individual. This maximum applies to any infertility expenses paid for Qualified Procedures, regardless of who provides them, under the Empire Plan's hospital plan, medical plan, and any allowed travel, lodging and meal expenses.

Exclusions and limitations

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

- Experimental infertility procedures. (Infertility procedures performed must be accepted as non-experimental by the American Society of Reproductive Medicine.)
- Fertility drugs prescribed in conjunction with Assisted Reproductive Technology and dispensed by a retail pharmacy are not covered under this benefit. Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under the Empire Plan.
- Medical expenses or other charges related to genetic selection
- Medical expenses or any other charges in connection with surrogacy
- Any donor compensation or fees charged in facilitating a pregnancy
- Any charges for services provided to a donor in facilitating a pregnancy
- Storage of sperm, eggs or embryos for more than 6 months
- Assisted Reproductive Technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant

- Psychological evaluations and counseling. See the GHI/ValueOptions Certificate for coverage that may be provided for psychological evaluations and counseling

Other exclusions and limitations that apply to this benefit are included under Exclusions in the General Provisions section of this Certificate.

Substitute the following for "H." under "Exclusions" in the "General Provisions" section on page 76 of your United HealthCare Certificate as amended in your March 1998 Empire Plan Report.

Experimental, Investigational or Unproven Services

H. Services deemed Experimental, Investigational or Unproven are not covered under this Plan. However, United HealthCare may deem an Experimental, Investigational or Unproven Service is covered under this Plan for treating a life threatening sickness or condition if:

1) it is determined by United HealthCare that the Experimental, Investigational or Unproven 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, or
2) Empire Plan benefits have been paid or approved by another Empire Plan carrier for the item or service based on a determination that the service or item is covered under the Empire Plan.

Experimental, Investigational or Unproven Services shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under **Miscellaneous Provisions** on page 84. If the External Appeal Agent approves coverage of an Experimental, Investigational or Unproven treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

Add the following at the end of "How, When and Where to Submit Claims" section on page 82 of your United HealthCare Certificate.

Denial of claim

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

- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service; or
- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written pre-authorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the pre-authorization; and

- You provide to United HealthCare proof of payment or pre-authorization of benefits from the other Empire Plan carrier regarding the availability of Empire Plan benefits to you for that medical procedure or service.

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

Substitute the following for the first paragraph under "Benefits after termination of coverage" in the "Miscellaneous Provisions" section on page 83 of your United HealthCare Certificate.

Totally disabled when coverage ends

Effective January 1, 2000. If you are totally disabled on the date coverage ends on your account, United HealthCare will pay benefits for covered medical 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. Call United HealthCare at 1-800-942-4640 if you need more information about benefits after termination of coverage.

Add the following at the end of the "Miscellaneous Provisions" section on page 84 of your United HealthCare Certificate.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if United HealthCare 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 procedure was presented for consideration, United HealthCare must have upheld the denial; **or** you and United HealthCare 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 additional information regarding the adverse determination was presented for consideration, United HealthCare must have upheld the denial; **or** you and United HealthCare 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 United HealthCare 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. United HealthCare will provide an external appeal application with the final adverse determination issued through United HealthCare'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 United HealthCare based its denial, the External Appeal Agent will share this information with United HealthCare in order for it to exercise its right to reconsider its decision. If United HealthCare chooses to exercise this right, United HealthCare will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), United HealthCare 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 United HealthCare. 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 United HealthCare 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 United HealthCare's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, United HealthCare 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, United HealthCare will only cover the costs of services required to provide treatment to you according to the design of the trial. United HealthCare 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 United HealthCare. The External Appeal Agent's decision is admissible in any court proceeding.

United HealthCare 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. United HealthCare 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 United HealthCare that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. United HealthCare has no authority to grant an extension of this deadline.

Certificate of Insurance

Substitute the following for the Certification on page 85 of your Certificate of Insurance for the Empire Plan Mental Health and Substance Abuse Program.

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-5243 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) January 1, 1999 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

ValueOptions

Substitute "ValueOptions" for "Value Behavioral Health" or "VBH" wherever either appears in the Certificate for the Mental Health and Substance Abuse Program.

Substitute the following for "United HealthCare Service Corp., P.O. Box 1600, Kingston, New York 12402-1600" wherever it appears in your Certificate for the Mental Health and Substance Abuse Program as amended in your Empire Plan Reports:

ValueOptions
P.O. Box 778
Troy, NY 12181-0778

Substitute the following for the United HealthCare Service Corp. telephone number wherever the telephone number appears in your Certificate for the Mental Health and Substance Abuse Program:

ValueOptions: 1-800-446-3995

GHI and ValueOptions

Substitute "GHI" for "Metropolitan" or "United HealthCare" wherever either appears in your Certificate for the Mental Health and Substance Abuse Program.
Exceptions to this substitution:

Substitute "ValueOptions" for "Metropolitan" in the fourth paragraph under "NON-NETWORK COVERAGE" on the "Schedule of Benefits for Covered Services," page 97 of your Certificate for the Mental Health and Substance Abuse Program as amended in your Empire Plan Reports.

and

Substitute "ValueOptions" for "United HealthCare" in the "How, When and Where to Submit Claims" section on pages 104-105 of your Certificate for the Mental Health and Substance Abuse Program as amended in your Empire Plan Reports.

Additional exceptions are included in Certificate amendments below.

Substitute the following under "Meaning of Key Terms" for "2." on page 87, "16." on page 89 and "29." on page 91 of your Certificate for the Mental Health and Substance Abuse Program.

Meaning of key terms

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

16. **GHI** means Group Health Incorporated, the insurer for the Empire Plan Mental Health and Substance Abuse Program.

29. **Program** means the Empire Plan Mental Health and Substance Abuse Program. This Program provides coverage under Group Policy No. PLH-5243 issued to the State of New York, the policyholder, by GHI. This Program replaces coverage for mental health and substance abuse care under Group Policy No. 34450-G issued to the State of New York by Metropolitan Life Insurance Company.

Substitute the following for the first two sentences of the last paragraph of "22." under "Meaning of Key Terms" on page 90 of your Certificate for the Mental Health and Substance Abuse Program.

Non-network allowance

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 service or supply you obtain under the non-network portion of the Program.

Add the following after "28 (d)." under "Meaning of Key Terms" on page 91 of your Certificate for the Mental Health and Substance Abuse Program.

Registered nurse practitioner

(e) 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.

Substitute the following for the paragraph under "Release of medical records" in the "How to Receive Benefits..." section on page 94 of your Certificate for the Mental Health and Substance Abuse Program.

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 the strictest confidence.

Substitute the following for the third and fourth paragraphs under "Certification denial and appeal process" in the "Concurrent Review" section on page 95 of your Certificate for the Mental Health and Substance Abuse Program.

Certification denial and appeal process

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 in 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.

Add the following at the end of "Outpatient care" in the "What is Covered..." section on page 96 of your Certificate for the Mental Health and Substance Abuse Program.

Outpatient care

11. **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.
12. **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.
13. **Telephone Counseling** provided by a network practitioner is covered.

    Benefits for these services are available under network coverage only.

Add the following as the seventh bullet in item "c" under "Network Coverage" in the "Schedule of Benefits" section on page 97 of your Certificate for the Mental Health and Substance Abuse Program.

Network Coverage

- No copayment is required for home-based counseling when provided in place of inpatient care.

Substitute the following for "6." under "Exclusions and Limitations" on page 99 of your Certificate for the Mental Health and Substance Abuse Program as amended in your March 1998 Empire Plan Report.

Exclusions and limitations

6. Services deemed Experimental, Investigational or Unproven are not covered under this Plan. However, ValueOptions and GHI may deem an Experimental, Investigational or Unproven Service is covered under this Plan for treating a life-threatening sickness or condition if they determine that the Experimental, Investigational or Unproven 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.

Experimental, Investigational or Unproven Services shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under **Miscellaneous Provisions** on page 107. If the External Appeal Agent approves coverage of an Experimental, Investigational or Unproven treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

Substitute the following for "11." under "Exclusions and Limitations" on page 99 of your Certificate for the Mental health and Substance Abuse Program.

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.

Delete the sidehead "Division of responsibilities" and the first paragraph under the heading "General Provisions" on page 100 of your Certificate for the Mental Health and Substance Abuse Program. Substitute the following for the second paragraph under the heading "General Provisions" on page 100 of your Certificate for the Mental Health and Substance Abuse Program.

Responsibilities

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.

Substitute the following for "8." under "Coordination of Benefits" in the "General Provisions" section on page 102 of your Certificate for the Mental Health and Substance Abuse Program.

Coordination of benefits

8. 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 paid by the other plan.

Substitute the following for "2. Non-network Coverage" under "Claim payment for covered services" in the "Claims" section on page 104 of your Certificate for the Mental Health and Substance Abuse Program.

Claim payment for covered services

2. **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 allowance for the covered service you obtained. You are always required to pay the inpatient and/or outpatient deductible and the amount billed to you in excess of the non-network allowance. Also, you are ultimately responsible for paying your provider any amount not paid by GHI. However, GHI will pay the non-network allowance directly to an approved facility in lieu of paying you.

Substitute the following for the last sentence in "3. Assignment Prohibited" under "Claim payment for covered services" in the "Claims" section on page 104 of your Certificate for the Mental Health and Substance Abuse Program.

Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, GHI or ValueOptions.

Substitute the following for the paragraph under "Verification of claims information" in the "How, When and Where to Submit Claims" section on page 105 of your Certificate for the Mental Health and Substance Abuse Program.

Verification of claims information

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

Substitute the following for the two paragraphs under "Questions" in the "How, When and Where to Submit Claims" section on page 105 of your Certificate for the Mental Health and Substance Abuse Program.

Questions

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call ValueOptions at the following toll-free number: 1-800-446-3995.

Conversion

Delete "Right to Convert;" from the section heading "Right to Convert; COBRA" and delete the first paragraph, "Right to convert to an individual policy" from this section on page 106 of your Certificate for the Mental Health and Substance Abuse Program.

Substitute the following for "Confined on effective date of coverage" under "Miscellaneous Provisions" on page 106 of your Certificate or the Mental Health and Substance Abuse Program.

Confined on January 1, 1999

- *Enrollees with Empire Plan Coverage in Effect Prior to January 1, 1999*
  If prior to January 1, 1999, when this GHI Policy took effect, you were enrolled in the Empire Plan and confined in a hospital or similar facility for care or treatment or were confined at home under a practitioner's care for mental health/substance abuse treatment, and you continue to be confined as of January 1, 1999, your Empire Plan mental health/substance abuse benefits continue under the provisions of the Metropolitan Policy in effect on December 31, 1998, until the date you are no longer so confined or July 1, 2000, whichever is earlier. Your benefits under this GHI Policy will begin the day after mental health/substance abuse benefits under the Metropolitan Policy end.

Confined on effective date of coverage

- *Enrollees with Empire Plan Coverage in Effect On or After January 1, 1999*

  If on or after January 1, 1999, the date you become eligible for coverage under the Empire Plan, you are confined in a hospital or similar facility or are confined at home under a practitioner's care for mental health/substance abuse treatment, the effective date of your coverage under this Program will be deferred until the date you are no longer confined.

  There is, however, an exception to this provision. This Program will pay benefits if you were so confined on the initial coverage date of the group of employees to which you belong. However, benefits are payable only to the extent that they exceed or are not payable through a former health insurance plan. When you are no longer confined, full Empire Plan benefits will apply to you.

Substitute the following for the first paragraph under "Benefits after termination of coverage" in the "Miscellaneous Provisions" section on page 106 of your Certificate for the Mental Health and Substance Abuse Program.

Totally disabled when coverage ends

Effective January 1, 2000. 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.

Insert the following at the end of "Appeals" in the "Miscellaneous Provisions" section on page 107 of your Certificate for the Mental Health and Substance Abuse Program.

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 procedure 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 additional information regarding the adverse determination 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.

CIGNA CERTIFICATE OF INSURANCE
Empire Plan Prescription Drug Program

Express Scripts

Substitute "Express Scripts" for "ValueRx" wherever it appears in your CIGNA Certificate.

Insert the following at the end of "M. Medically Necessary" in the "Meaning of Terms Used" section on page 110 of your CIGNA Certificate.

Medically necessary

If Express Scripts denies your claim 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 Express Scripts 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.

Substitute the following for "Copayments," "Mandatory Generic Substitution" and "Higher cost for most brand names" in the "Your Benefits and Responsibilities" section on pages 110-111 of your CIGNA Certificate.

Copayments: $5 generic/ $15 brand-name

Effective January 1, 2000. Your copayment for up to a 90-day supply is $5 for generic drugs and $15 for brand-name drugs with no generic equivalent. For brand-name drugs with a generic equivalent, you pay a $15 copayment plus the difference in cost between the brand-name drug and its generic equivalent. This cost difference can be substantial.

The copayment applies to prescriptions dispensed at a participating pharmacy and at Express Scripts Mail Service. 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.

Mandatory Generic Substitution

When your prescription is written for a brand-name drug that has a generic equivalent, Empire Plan coverage will be limited to the cost of the drug's generic equivalent. The Plan will cover the cost of brand-name drugs which have no generic equivalent.

Higher cost for brand-name drugs

When you use your card at a participating pharmacy, if your prescription is written for:

- **A brand-name drug with a generic equivalent** – You will pay a $15 copayment *plus* the difference in cost between the brand-name and generic drug, not to exceed the full cost of the drug. This cost difference can be substantial.

  The following brand-name drugs are excluded from Mandatory Generic Substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Slo-Bid, Synthroid, Tegretol and Theo-Dur. You pay only the $15 copayment.
- **A brand-name drug with no generic equivalent** – You pay only the $15 copayment.
- **A generic drug** – You pay only the $5 copayment.

Remember, if your doctor insists on prescribing a brand-name drug that has a generic equivalent, you will pay your $15 copayment plus the difference in cost between the brand-name and the generic drug.

If your doctor feels it is medically necessary for you or your family member to have a brand-name drug (that has a generic equivalent), you can appeal the Mandatory Generic Substitution requirement. Call 1-800-964-1888 for an appeal form which you and your doctor must complete. Or, you can write for a generic appeal form to:

Empire Plan Prescription Drug Program
P.O. Box 749
Troy, New York 12181-0749.

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

If your appeal is granted, you can fill your prescription for the brand-name drug at an Empire Plan/Express Scripts participating pharmacy or through the mail service pharmacy and pay only the $15 copayment. If your appeal is denied, you can make a second appeal to be reviewed by CIGNA, the program insurer.

Substitute the following for "Prior authorization," "You must call" and "The review process" in the "Your Benefits and Responsibilities" section on pages 111-112 of your CIGNA Certificate as amended in your July 1999 Empire Plan Report.

Prior authorization

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for the following drugs purchased at a pharmacy:

- BCG Live
- Ceredase or Cerezyme
- Drugs for the treatment of impotency
- Enbrel
- Epoetin
- Human Growth Hormone
- Immune Globulin
- Lamisil
- Prolastin
- Pulmozyme
- Sporanox

These drugs can have medical results of immeasurable value, but they are sometimes prescribed inappropriately. The Prior Authorization Program ensures that these drugs are used appropriately, for medically necessary treatments.

You must call 1-800-964-1888 for prior authorization for certain drugs

When a claim from a participating retail or mail service pharmacy is submitted for one of these drugs, the review process is initiated when the pharmacist receives the message, "Prior authorization required." The pharmacist, you, a member of your family, your doctor or your doctor's staff must call Express Scripts at 1-800-964-1888 to begin the review process. However, you are ultimately responsible for getting prior authorization if your doctor prescribes a drug on the prior authorization list.

The review process

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 will allow you or your doctor to ask for further review if authorization is not granted. You may call Express Scripts at 1-800-964-1888 for information on how to initiate an appeal.

The Prior Authorization requirements apply whenever you use Empire Plan Prescription Drug Program benefits for these drugs. You must call for Prior Authorization whether you use your New York Government Employee Benefit Card or will be filing a claim for direct reimbursement.

Substitute the following for the sentence under "Empire Plan Prescription Drug Program" under "Important Telephone Numbers" on the back cover of your January 1, 1996 NYSHIP General Information Book and Empire Plan Certificate as amended in your July 1999 Empire Plan Report.

You must call for prior authorization for BCG Live, Ceredase or Cerezyme, Drugs for the treatment of impotency, Enbrel, Epoetin, Human Growth Hormone, Immune Globulin, Lamisil, Prolastin, Pulmozyme, or Sporanox.

Insert the following at the end of "K." under "Exclusions and Limitations" in the "Your Benefits and Responsibilities" section on page 113 of your CIGNA Certificate.

Experimental or investigational drugs

Experimental or investigational drugs shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under **Miscellaneous Provisions** on page 118. 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 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.

Add the following at the end of "Claims appeal" in the "Miscellaneous Provisions" section on page 118 of your CIGNA Certificate.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if CIGNA has denied coverage on the basis that the 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 Program; and

B. You must have received a final adverse determination through the internal appeal process described above and CIGNA must have upheld the denial **or** you and CIGNA 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 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 CIGNA must have upheld the denial **or** you and CIGNA 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 prescription drugs are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard prescription drug covered by the Program.

In addition, your attending physician 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 physician 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 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 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 CIGNA 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. CIGNA will provide an external appeal application with the final adverse determination issued through CIGNA'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 CIGNA based its denial, the External Appeal Agent will share this information with CIGNA in order for it to exercise its right to reconsider its decision. If CIGNA chooses to exercise this right, CIGNA will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), CIGNA 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 CIGNA. 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 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 CIGNA 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 CIGNA's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, CIGNA 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 CIGNA. The External Appeal Agent's decision is admissible in any court proceeding.

CIGNA 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. CIGNA 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 CIGNA that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. CIGNA has no authority to grant an extension of this deadline.

Substitute the following for "Empire Plan Prescription Drugs" under "Empire Plan Copayments" on page 120 of your Empire Plan Certificate.

Copayments

Generic Drug $5

Brand-Name Drug
with no generic equivalent $15

Brand-Name Drug
with a generic equivalent (with some exceptions).....$15 copayment plus difference in cost between brand-name drug and its generic equivalent.

Empire Plan Telephone Numbers

YOU MUST CALL

Empire Plan's Benefits Management Program 1-800-992-1213

- You must call before a maternity or scheduled hospital admission.
- You must call within 48 hours after an emergency or urgent hospital admission.
- You must call before admission or transfer to a skilled nursing facility.
- You must call before having an elective (scheduled) Magnetic Resonance Imaging (MRI).

If you do not follow the Benefits Management Program requirements, you will pay a higher share of the costs.

YOU MUST CALL

ValueOptions (administrator for GHI).....1-800-446-3995

You must call ValueOptions before beginning any treatment for mental health or substance abuse, including alcoholism. If you do not follow ValueOptions requirements, you will receive a significantly lower level of benefits. In a life-threatening situation, go to the emergency room. Call within 48 hours.

Empire Blue Cross and Blue Shield .....518-367-0009 (Albany area and Alaska)
1-800-342-9815 (NYS and other states except Alaska)

New York State Service Center, 11 Corporate Woods Blvd., Albany, NY 12211

Call for information regarding hospital and related services.

United HealthCare Insurance Company of New York 1-800-942-4640

P.O. Box 1600, Kingston, NY 12402-1600

Call for information on benefits under Basic Medical and Participating Provider Programs, predetermination of benefits, claims and participating providers.

YOU MUST CALL

Home Care Advocacy Program (HCAP).....1-800-638-9918

You must call to arrange for paid-in-full home care services and/or durable medical equipment/supplies. If you do not follow HCAP requirements, you will receive a significantly lower level of benefits.

Managed Physical Medicine Program/MPN.....1-800-942-4640

Call for information on benefits and to find MPN network providers for chiropractic treatment and physical therapy. If you do not use MPN network providers, you will receive a significantly lower level of benefits.

YOU MUST CALL

Infertility Benefits.....1-800-638-9918

You must call for prior authorization for the following Qualified Procedures, regardless of provider: Artificial Insemination; Assisted Reproductive Technology (ART) procedures including in-vitro fertilization and embryo placement, Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Intracytoplasmic Sperm Injection (ICSI) for the treatment of male infertility, assisted hatching and microsurgical sperm aspiration and extraction procedures; sperm, egg and/or inseminated egg procurement and processing and banking of sperm and inseminated eggs. Call for Centers of Excellence.

The Empire Plan NurseLine℠.....1-800-439-3435

Call for health information and advice, 24 hours a day, seven days a week. To listen to the Health Information Library, enter PIN 335 and a 4-digit topic code from the Empire Plan NurseLine brochure. Also check Health Forums on the Web at www.healthforums.com/empire.

YOU MUST CALL

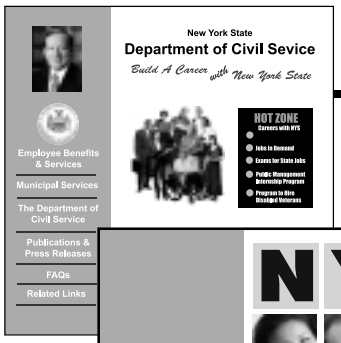
Empire Plan Prescription Drug Program 1-800-964-1888

Express Scripts, P.O. Box 1180, Troy, NY 12181-1180. You must call for prior authorization for BCG Live, Ceredase or Cerezyme, drugs for the treatment of impotency, Enbrel, Epoetin, Human Growth Hormone, Immune Globulin, Lamisil, Prolastin, Pulmozyme or Sporanox.

TTY (Text Telephone) lines for hearing-impaired or speech-impaired callers with TTY devices:

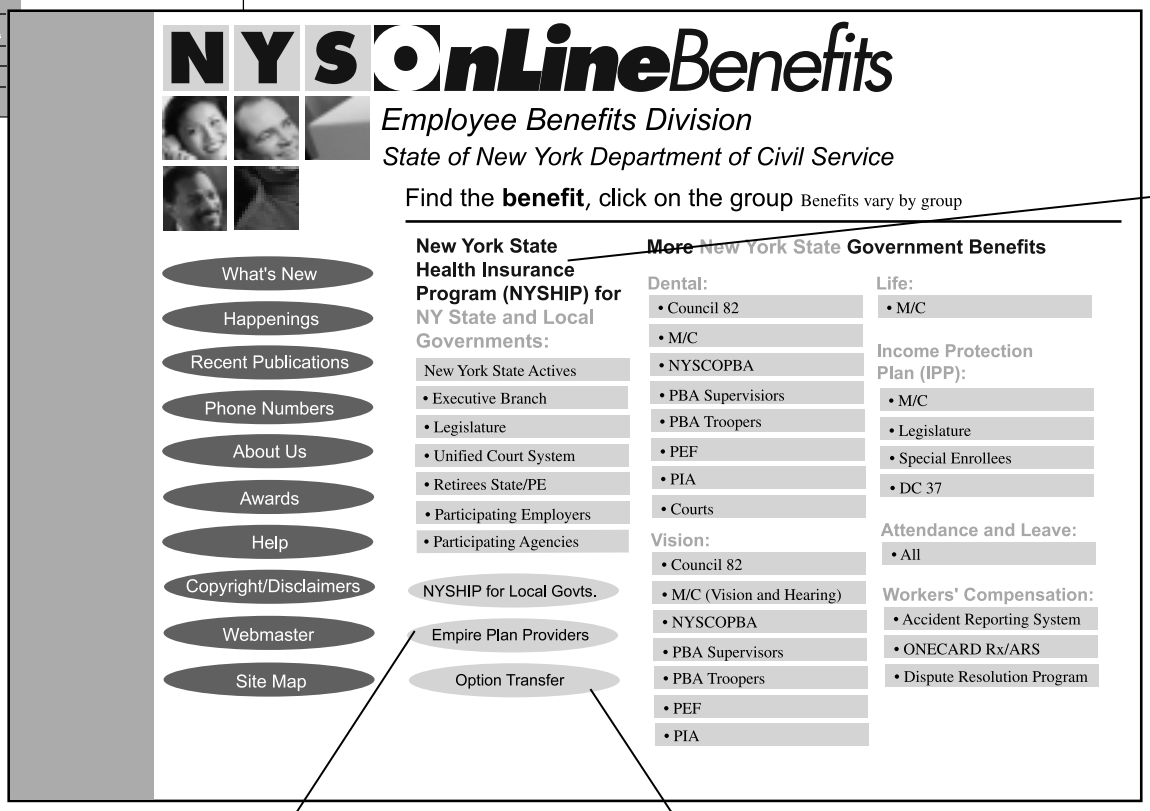
Benefits Management Program.....TTY only: 1-800-962-2208
ValueOptions .....TTY only: 1-800-334-1897
Empire Blue Cross and Blue Shield .....TTY only: 1-800-241-6894
United HealthCare and Managed Physical Medicine Program.....TTY only: 1-888-697-9054
Empire Plan Prescription Drug Program .....TTY only: 1-800-840-7879

Visit us on the Web at http://www.cs.state.ny.us



Check our newly-designed New York State Department of Civil Service Employee Benefits Division Web site at http://www.cs.state.ny.us.

Click on Employee Benefits and Services for timely information about your Empire Plan benefits.



Health Insurance
Choose your group to go to *"What's Inside"* for information about NYSHIP and the Empire Plan

Empire Plan Providers
Link directly to the Participating Provider Directory on the United HealthCare Web site

Option Transfer
Health insurance options for New York State employees and employees of Participating Employers

It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

GIB-EP/MC/00-1

Save this document
NYSHIP/Empire Plan Information
for the Enrollee, Enrolled Spouse/Domestic Partner
and Other Enrolled Dependents

State of New York
Department of Civil Service
Employee Benefits Division
The State Campus
Albany, New York 12239
http://www.cs.state.ny.us

ADDRESS SERVICE
REQUESTED

PRSRT STD
U.S. Postage Paid
Utica, NY
Permit No. 320