New York State
Health Insurance Program

General Information Book and Empire Plan Certificate

Certificate Amendments

For New York State Police Supervisors represented by

Police Benevolent Association and for their enrolled dependents
and for COBRA enrollees with their benefits

May 2000
State of New York
Department of Civil Service
Employee Benefits Division

Keep this booklet with your April 1, 1999 *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 April 1, 1999 *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" section on page I-25 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.

Insert the following as the fifth paragraph under "Lifetime monthly credit" in the "Continuing Coverage When You Retire" section on page I-28 of your NYSHIP General Information Book.

Sick Leave Credit

When you retire, if the dollar value of your sick leave credit 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 runout sick leave method.

Insert the following after the third paragraph under "Deferred Health Insurance Coverage" on page I-32 of your NYSHIP General Information Book.

Deferred health insurance coverage

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 and coverage" in the "COBRA: Continuation of Coverage" section on page I-39 of your NYSHIP General Information Book.

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 I-3.

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 I-39 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 I-40 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 I-40 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 I-41 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 I-43 of your NYSHIP General Information Book as amended in your August 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 I-43 of your NYSHIP General Information Book as amended in your August 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 I-44 of your NYSHIP General Information Book.

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.

Substitute the following for "7. Intravenous Chemotherapy" in the "Outpatient Hospital Care" section on page I-72 of your Blue Cross Certificate.

Outpatient chemotherapy

7. **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.

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 I-76 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 I-90, 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 I-78 of your Blue Cross Certificate.

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 I-90. 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 I-88 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 I-88 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 I-89 of your NYSHIP General Information Book.

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 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 I-90 of your Blue Cross 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 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 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 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 I-90 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:

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	UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK
By:	By:
Name: Craig J. Griffin	Name: M. Laurie Wasserstein
Title: Vice-President	Title: Vice President
Date: 2/7/00	Date: 2-4-00

219341.1

Add the following at the end of "Meaning of Terms Used" on page I-102 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 an appointment.

Substitute the following for the second and third paragraphs in the "Participating Provider Program" section on page I-102 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 in the "Participating Provider Program" section on page I-103 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 I-106 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 I-111 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 "H." under "Exclusions" in the "General Provisions" section on page I-121 of your United HealthCare Certificate.

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 Blue Cross 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 I-134. 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 I-129 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.

Add the following at the end of the "Miscellaneous Provisions" section on page I-134 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 rights 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.

Add the following after "28 (d)." under "Meaning of Key Terms" on page I-143 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 I-148 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 I-149 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 I-151 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.** 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 I-153 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 I-155 of your Certificate for the Mental Health and Substance Abuse Program.

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 I-167. 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 I-156 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 "Division of responsibilities" and the paragraph under "Division of Responsibilities" in the "GHI General Provisions" section on page I-157 of your Certificate for the Mental Health and Substance Abuse Program. Substitute the following for the second paragraph under "GHI General Provisions" on page I-157 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 "GHI General Provisions" section on page I-160 of your Certificate or 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.

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 I-165 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 I-165 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.

Insert the following at the end of "Appeals" in the "Miscellaneous Provisions" section on page I-167 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 rights 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.

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 I-170 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 "Prior authorization," "You must call..." and "The review process" in the "Your Benefits and Responsibilities" section on pages I-172–I-173 of your CIGNA Certificate.

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.

Insert the following at the end of "K." under "Exclusions and Limitations" in the "Your Benefits and Responsibilities" section on page I-174 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 I-182. 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 I-182 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 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 or procedure 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.

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 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

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.

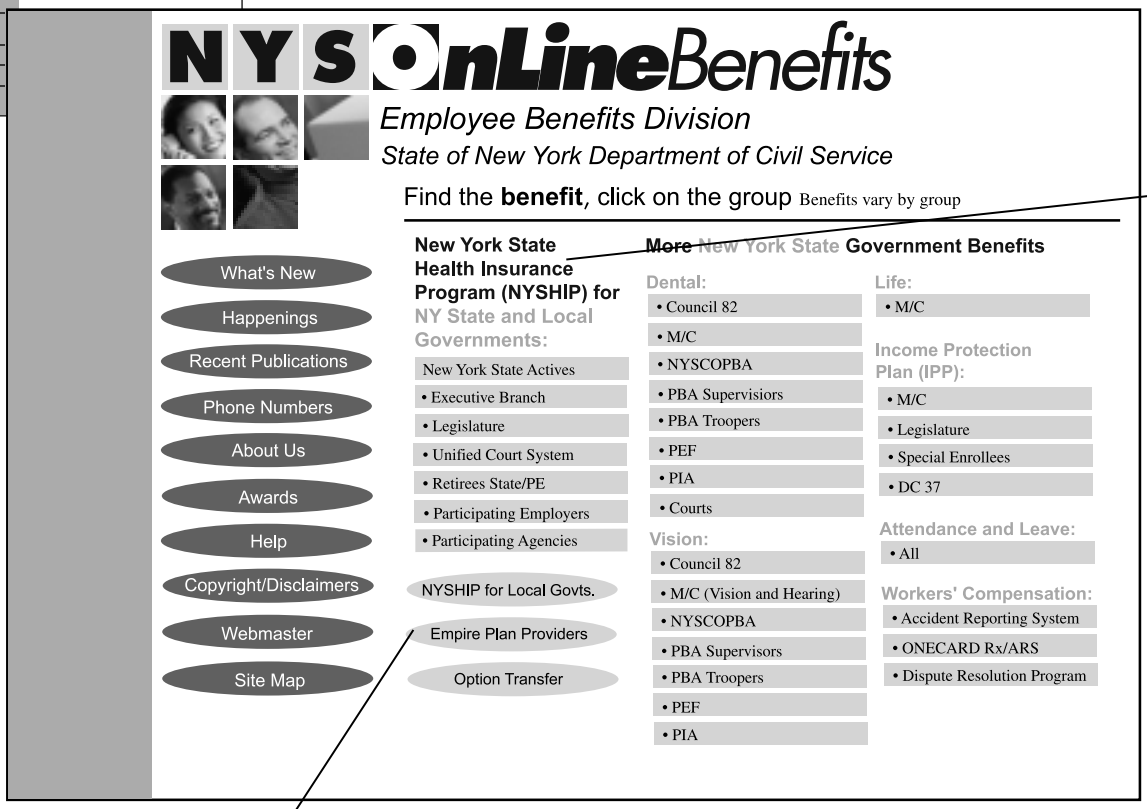
TTY (Text Telephone) lines for hearing-impaired or speech-impaired callers with TTY devices:

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 .....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

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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/PBA-S/00-1

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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

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