Keep these amendments with your June 1, 2002 *New York State Health Insurance Program General Information Book and Empire Plan Certificate.*

Pages in your Book/Certificate and later Certificate Amendments have consecutive numbers.

General Information Book & Empire Plan Certificate Amendments

For Employees of the State of New York represented by **Public Employees Federation (PEF)** and for their enrolled dependents *and for COBRA enrollees with their benefits*

September 2005

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

New York State Health Insurance Program General Information Book

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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 June 1, 2002 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports* and *Certificate Amendments,* this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

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

Domestic partner

Effective January 1, 2005. To enroll a domestic partner, you must have been in the partnership for six months and be able to provide proof of residency and financial interdependence.

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

Effective January 1, 2005. There will be a one-year waiting period from the termination date of your previous partner's coverage before you may again enroll a domestic partner.

Substitute the following for the second paragraph under "When your Family coverage begins" in the "Coverage: Individual or Family" section on page 9 of your NYSHIP General Information Book.

Pre-Tax Contribution Program

If you and a spouse or domestic partner each have Individual coverage in NYSHIP and you change to one Family coverage, there is no waiting period. Note: If you participate in the Pre-Tax Contribution Program (PTCP), federal regulations allow only one spouse or domestic partner with Individual coverage to change to Family coverage upon acquisition of a dependent child. The other spouse or domestic partner with Individual coverage must retain that coverage until the Pre-Tax Election Period. Then that enrollee can cancel Individual coverage and choose to be covered as a dependent under Family coverage.

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

Substitute the following for the first paragraph, "Your card" under "Identification Cards" on page 11 of your NYSHIP General Information Book.

Identification card

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

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

Sample Empire Plan Benefit Card for Empire Plan Enrollees

The nine digits are your alternate Identification Number.

The Blue Cross Inter-Plan Bank Code is YLS. Out-of-State hospital claims submitted with this code will reach the correct Blue Cross plan.

Substitute the following for the information in the box under "Disability retirement" in the "Continuing Coverage When You Retire" section on page 20 of your NYSHIP General Information Book.

Disability retirement

To maintain NYSHIP eligibility, you must continue your health insurance coverage while you wait for the decision on your disability retirement. If you do not continue coverage or if you fail to make the required payments while on leave or in vestee status, coverage for you and your dependents will end. Coverage may end permanently. If your disability retirement is not approved, you will not be eligible to re-enroll in NYSHIP.

Deadline: If you have not continued your coverage and a retroactive retirement is granted, call the Employee Benefits Division right away at 518-457-5754 (Albany area) or 1-800-833-4344 to ask about reinstating coverage. Call as soon as you have the decision on your disability retirement. You must apply in writing for reinstatement of your NYSHIP coverage **within one year** of the date on the letter from your retirement system announcing the decision to grant your disability retirement. If coverage is reinstated due to your receipt of a disability retirement, you will be required to pay any missed premiums, based upon the last coverage in effect, from the date your coverage terminated until the date your coverage would have ended if your retirement had been granted on a timely basis.

If you receive an ordinary disability retirement, the effective date of your coverage will follow a three month late enrollment waiting period based on the date of your application.

If you receive a work-related disability retirement, you may choose your effective date of coverage to be based on your date of retirement or on a current basis.

Substitute the following for the first paragraph of "How long you may keep COBRA coverage" in the "COBRA: Continuation of Coverage" section on pages 29-30 of your NYSHIP General Information Book.

COBRA coverage for disabled

You, the employee, will have the opportunity to maintain continuation coverage for 18 months. However, the continuation coverage period will be extended to 29 months for you and your enrolled dependents if you or a dependent is disabled (under Social Security Act provisions defining disabilities). If you are disabled under Social Security at the time of COBRA election, you must notify the Employee Benefits Division within the first 60 days of COBRA coverage in order to qualify for the 11-month extension for the disabled. If you become disabled under Social Security during COBRA continuation, you must notify the Employee Benefits Division within 60 days of the date of the notice of disability and prior to the end of the 18-month COBRA continuation period in order to qualify for the 11-month extension period.

Substitute the following for "When you no longer qualify for COBRA coverage" in the "COBRA: Continuation of Coverage" section on page 30 of your NYSHIP General Information Book as amended in your January 2004 Empire Plan Report.

When you no longer qualify for COBRA coverage

Continuation coverage may be cut short for any of the following reasons:

1. If New York State no longer provides group health care coverage to any of its employees; or
2. If the premium for your continuation coverage is not paid on time; or
3. The continuation period of 18 months, 29 months or 36 months ends; or
4. If you become eligible for Medicare after enrolling in COBRA, your COBRA coverage ends when you become entitled to receive Medicare benefits. (In this case, your covered dependents may continue COBRA coverage for up to 18 months (or 29 months if entitled to the 11-month disability extension) from their original COBRA qualifying event.)

THE EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM

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

Pre-admission certification

Effective January 1, 2005. If you do not follow the pre-admission certification requirements:

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

or

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

or

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

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

and

- **Effective January 1, 2005,** you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

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

If you call the Benefits Management Program and if hospitalization for you or your family member is not certified, you may choose to go ahead with the hospitalization. If you do, you will be required to pay all charges.

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

Prospective procedure review: MRI

Effective January 1, 2005. If you fail to call and the Empire Blue Cross Blue Shield 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 applicable outpatient hospital copayment or coinsurance.
- When the provider(s) administering and/or interpreting the MRI is an Empire Plan participating provider under the Medical Program, you are liable for the payment of the lesser of 50 percent of the scheduled amounts or $250. You will also be responsible for the $15 copayment.

EMPIRE BLUE CROSS BLUE SHIELD CERTIFICATE OF INSURANCE

Insert the following under "2." of "Introduction" on page 50 of your Empire Blue Cross Blue Shield Certificate.

Network and non-network facilities

Effective January 1, 2005. Network hospitals and facilities means hospitals and facilities that participate in the Blue Cross and Blue Shield Association Blue Card PPO® Program through local Blue Cross and/or Blue Shield plans. When you use network hospitals and facilities, covered services are paid in full subject to the Benefits Management Program requirements and except for any applicable copayments that you pay.

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

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

Hospital admission

Effective January 1, 2005. If you do not follow the provisions of the Benefits Management Program, Empire Blue Cross Blue Shield will still review your claim and will apply the following deductibles and copayments:

- If you did not call the Benefits Management Program for Pre-Admission Certification of an elective (scheduled) inpatient admission or an admission for the birth of a child, Empire Blue Cross Blue Shield will apply a $200 hospital deductible. Effective January 1, 2005, no payment will be made for any day during which it was not medically necessary for you to be an inpatient.

- If you called the Benefits Management Program and did not receive certification for your admission and you are admitted to the hospital as an inpatient, you will be responsible for all charges for each day it was not medically necessary for you to be an inpatient. If only a part of your inpatient stay was certified, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.
- If you did not call the Benefits Management Program within 48 hours after an emergency or urgent hospital admission, Empire Blue Cross Blue Shield will apply a $200 hospital deductible. In addition, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

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

Substitute the following for the last two sentences of "Outpatient MRI" in the "Benefits Management Program" section on page 52 of your Empire Blue Cross Blue Shield Certificate.

Outpatient MRI

Effective January 1, 2005. If you fail to call the Benefits Management Program and Empire Blue Cross Blue Shield's review confirms that your procedure was medically necessary, but not an emergency, you will be responsible for paying the lesser of 50 percent of the covered hospital charge or $250. The applicable hospital outpatient copayment or coinsurance will be applied to the remaining covered charge.

Insert the following before "Inpatient Hospital Care" on page 52 of your Empire Blue Cross Blue Shield Certificate.

Network and Non-Network Benefits

Network and non-network benefits

Effective January 1, 2005. The following applies to enrollees who have primary coverage through The Empire Plan.

There are two levels of benefits under the Hospital Program – Network and Non-network.

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

The **annual coinsurance maximum** for covered inpatient/outpatient services received at a non-network hospital and covered inpatient services received at a non-network skilled nursing facility or hospice care facility is $1,500 for the enrollee, $1,500 for the enrolled spouse/domestic partner, and $1,500 for all dependent children combined. After the maximum levels have been reached, inpatient services are paid in full, hospital emergency room visits are subject to a $50 copayment, hospital outpatient services are subject to a $35 copayment and physical therapy services are subject to a $15 copayment. Once you have paid $500 in non-network coinsurance, amounts in excess of $500 are reimbursable under the Basic Medical Program (see page 173 of these Empire Plan Amendments).

Non-network coinsurance and copayment amounts apply in addition to any deductible and coinsurance amounts that are your responsibility because of your failure to meet the requirements of the Benefits Management Program.

3. Network benefits at a non-network hospital/facility: If you use non-network hospitals and facilities you will receive network benefits for covered services:
   A. When no network facility is available within 30 miles of your residence;
   B. When no network facility within 30 miles of your residence can provide the covered services you require;
   C. When the admission is deemed by Empire Blue Cross Blue Shield as an emergency or urgent inpatient or outpatient admission;
   D. When care is received outside the United States;
   E. When another insurer, including Medicare is providing primary coverage.

The Empire Plan Blue Cross Blue Shield payment for medically necessary covered services received in a non-network hospital is made directly to you. You pay any applicable outpatient copayment at the network level and any deductibles or coinsurance amounts that apply because of your failure to follow the requirements of the Benefits Management Program. You are responsible for making the payment to the non-network hospital.

Empire Plan network hospitals, hospices and skilled nursing facilities are listed on the New York State Department of Civil Service web site at www.cs.state.ny.us. Click on Employee Benefits, then on Empire Plan Providers, Pharmacies and Services. You can also call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire Blue Cross Blue Shield.

Substitute the following for the first sentence of "2. Hospital services covered." in the "Inpatient Hospital Care" section on page 52 of your Empire Blue Cross Blue Shield Certificate.

Inpatient hospital care

Effective January 1, 2005. Empire Blue Cross Blue Shield will usually pay, subject to network and non-network benefit levels, for all the diagnostic and therapeutic services provided by the hospital.

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

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

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

Outpatient hospital care

Effective January 1, 2005. When you receive the services described in the following sections and subject to the limitations in those sections, Empire Blue Cross Blue Shield will pay for the same services provided to you in the outpatient department of a hospital as Empire Blue Cross Blue Shield pays when you are an inpatient in a hospital as described on page 52 under *"Inpatient Hospital Care."* This coverage also applies to services provided at a hospital extension clinic (a remote location including ambulatory surgical centers) owned and operated by the hospital. As in the case of inpatient care, the service must be given by an employee or an agent of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service.

Substitute the following for the second paragraph under "5. Physical therapy." in the "Outpatient Hospital Care" section on page 54 of your Empire Blue Cross Blue Shield Certificate as amended in your June 2003 Empire Plan Report.

Physical therapy

Effective January 1, 2005. You pay a $15 copayment for each visit to the outpatient department of a network hospital or the greater of 10 percent of charges or $75 at a non-network hospital for physical therapy when covered by Empire Blue Cross Blue Shield. This payment is in addition to any other payment, either copayment or coinsurance, applied to outpatient services rendered on the same day.

Substitute the following for the first sentence of "7. Chemotherapy." in the "Outpatient Hospital Care" section on page 54 of your Empire Blue Cross Blue Shield Certificate.

Chemotherapy

7. **Chemotherapy**. Empire Blue Cross Blue Shield pays for chemotherapy, except if you are enrolled in the United HealthCare Centers of Excellence Program and receiving care at a Cancer Resource Services network facility.

Substitute the following for "$35 copayment for emergency care" in the "Outpatient Hospital Care" section on pages 54-55 of your Empire Blue Cross Blue Shield Certificate.

Copayment for emergency care

Effective January 1, 2005. You must pay the first $50 in charges (copayment) for emergency care in a hospital emergency room. See *page 53, "Outpatient Hospital Care"* for emergency care. Hospitals may require payment of this charge at the time of service.

The $50 emergency room copayment covers use of the facility for **emergency care** *and* services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services. Refer to your United HealthCare Certificate, *page 81, "What is Covered Under the Basic Medical Program (non-participating providers),"* if you receive bills for hospital emergency room service from these providers.

You will not have to pay this $50 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for "$25 copayment for outpatient hospital services" in the "Outpatient Hospital Care" section on pages 54-55 of your Empire Blue Cross Blue Shield Certificate.

Copayment for outpatient hospital services

Effective January 1, 2005. You must pay the first $35 in charges (copayment) for each visit to a network facility or the greater of 10 percent of charges or $75 at a non-network facility where you receive one or more of the following covered hospital outpatient services, and hospitals may require payment of this charge at the time of service:

- Surgery

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

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

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

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

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

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

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

Skilled nursing facility

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

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

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

Effective January 1, 2005, coverage is subject to the network and non-network level of benefits.

Substitute the following for "1. Hospice organizations." in the "Hospice Care" section on page 55 of your Empire Blue Cross Blue Shield Certificate.

Hospice care

1. **Hospice organizations.** Empire Blue Cross Blue Shield will pay for hospice care provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided.

Effective January 1, 2005, coverage is subject to the network and non-network level of benefits.

Add the following after the first paragraph under "Centers of Excellence for Transplants Program" on page 56 of your Empire Blue Cross Blue Shield Certificate.

Centers of Excellence for Transplants Program

If an enrollee has secondary coverage under The Empire Plan, and the enrollee's primary insurer/HMO denies coverage at a facility described below that is covered under the Centers of Excellence for Transplants Program, The Empire Plan will be considered the enrollee's primary coverage for purposes of this section. The enrollee or the enrollee's primary health plan must send the denial letter to Empire Blue Cross Blue Shield. For assistance with this process, contact The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire Blue Cross Blue Shield.

Substitute the following for the second paragraph of "Infertility Benefits" and for "Maximum lifetime benefit" in the "Infertility Benefits" section on page 57 of your Empire Blue Cross Blue Shield Certificate as amended in your June 2003 Empire Plan Report.

Infertility benefits

Effective January 1, 2005. Infertility benefits, including Qualified Procedures (see below), are subject to the same copayments and deductibles as benefits for other medical conditions under the hospital program. Qualified Procedures are subject to a $50,000 lifetime maximum.

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

Insert the following as the second paragraph of "3. Recovery of overpayments" in the "Miscellaneous Provisions" section on page 66 of your Empire Blue Cross Blue Shield Certificate.

Recovery of overpayments

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident or due to medical malpractice, and we pay benefits as a result of that injury or illness, we will be subrogated to and shall succeed to all rights of recovery against the party responsible for your illness or injury to the reasonable value of any benefits we have paid. This right is limited to the amount of the settlement that represents medical expenses that have been paid. This means that we have the right, as a plaintiff-intervener in the action you may commence, to proceed against the party responsible for your injury or illness to recover the benefits we have paid. However, we shall not exercise our right to bring an independent action if you do not pursue a claim.

UNITED HEALTHCARE CERTIFICATE OF INSURANCE

Substitute the following for "Note" in the "Plan Overview" section on page 72 of your United HealthCare Certificate.

Plan overview

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

$15 copayment

Effective January 1, 2005. *Substitute "$15 copayment" for "$12 copayment" wherever the $12 appears in your United HealthCare Certificate as amended in your June 2003 Empire Plan Report.*

Substitute the following for "Hospital admission" on page 73 of your United HealthCare Certificate.

Hospital admission

Effective January 1, 2005. If you have a hospital admission which is covered under this Plan, you must comply with the **Pre-Admission Certification** requirements. If you do not comply, you will be subject to paying a $200 inpatient deductible if any portion of the hospitalization is determined to be medically necessary. Effective January 1, 2005, you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

Coinsurance maximum

Substitute "$1,486 for calendar year 2005" in the first and second paragraphs of "T. 2. b. The covered percentage" under "Meaning of Terms Used" on pages 76-77 of your United HealthCare Certificate.

Substitute the following for the third paragraph of "T. 2. b." of "Meaning of Terms Used" on page 77 of your United HealthCare Certificate.

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

Substitute the following for "U. Outpatient" in the "Meaning of Terms Used" section on page 77 of your United HealthCare Certificate.

Outpatient

U. **Effective January 1, 2005. Outpatient** means that covered medical expenses are incurred in a doctor's office, in the outpatient department of a hospital or in a hospital extension clinic (a hospital owned and operated remote location including an ambulatory facility).

Substitute the following for the third sentence of "Infertility Benefits requirements apply…" on page 74 and the second sentence of "X. The Lifetime Maximum" under "Meaning of Terms Used" on page 77 of your United HealthCare Certificate.

Infertility benefits maximum

Effective January 1, 2005. The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is $50,000 per covered person under The Empire Plan hospital and medical programs.

Insert the following as the fourth sentence in "A. Office and Home Visits" under "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 78 of your United HealthCare Certificate as amended in your June 2003 Empire Plan Report.

Meningitis immunization

The meningitis immunization is also a covered expense for dependent students age 19 and over.

Add the following at the end of "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 80 of your United HealthCare Certificate.

Prostheses and orthotic devices

T. **Effective January 1, 2005. Prostheses and Orthotic Devices** – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs. Replacements, when functionally necessary, are also covered. There is no copayment for the prosthesis and/or orthotic device when you use a participating provider. Mastectomy bras obtained from participating providers are covered in accordance with this benefit.

Add the following as the third paragraph in the "Basic Medical Program" section on page 80 of your United HealthCare Certificate.

Basic Medical Provider Discount Program

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

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

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

Substitute the following for "Assignment of benefits..." in the "Basic Medical Program" section on page 81 of your United HealthCare Certificate.

Assignment of benefits

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

Substitute the following for the first sentence of "A. Annual Deductible" under "You must meet a deductible and pay 20% coinsurance..." in the "Basic Medical Program" section on page 81 of your United HealthCare Certificate.

Annual deductible

For calendar year 2005, the Basic Medical annual deductible for medical services performed and supplies prescribed by non-participating providers is $309 for the enrollee, $309 for the enrolled spouse/domestic partner, and $309 for all dependent children combined.

Substitute the following for the last paragraph of "1. Hospitals" under "What is covered ..." in the "Basic Medical Program" section on page 82 of your United HealthCare Certificate.

Coverage

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

Add the following after "A. Hospitals" under "What is covered ..." in the "Basic Medical Program" section on page 82 of your United HealthCare Certificate. (Adjust the letters that follow.)

Non-network Hospital Program expenses

B. **Effective January 1, 2005. Non-network Hospital, Skilled Nursing Facility and Hospice Care Facility Out-of-Pocket Expenses** – If The Empire Plan provides your primary coverage and you incur out-of-pocket expenses under the Hospital Program as the result of using a non-network hospital, skilled nursing facility or hospice care facility for covered services, you may submit a claim to United HealthCare for reimbursement of any such expenses over $500 up to the combined $1,500 non-network hospital, skilled nursing facility or hospice care facility coinsurance maximum. This reimbursement is not subject to the Basic Medical deductible or coinsurance. **Any hospital deductibles or coinsurance amounts applied because you failed to meet the requirements of the Benefits Management Program are not reimbursable nor do they count toward the $500 threshold for reimbursement.** You must provide United HealthCare with a copy of your Empire Blue Cross Blue Shield explanation of benefits to document the amount of your covered out-of-pocket expense.

Radiology, anesthesiology, pathology

C. **Effective January 1, 2005. Radiology, Anesthesiology and Pathology** – If you receive anesthesia, radiology or pathology services in connection with inpatient or outpatient hospital services at an Empire Plan network hospital, and The Empire Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by United HealthCare.

Substitute the following for "J. Emergency Ambulance Service" under "What is covered..." in the "Basic Medical Program" section on page 82 of your United HealthCare Certificate.

Ambulance Service

L. **Ambulance Service** – Emergency ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and ambulance transportation is required because of an emergency condition. Medically necessary non-emergency transportation is covered if provided by a licensed ambulance service.

Covered medical expenses for ambulance service are:

1. Local commercial ambulance charges except for the first $35. *These amounts are not subject to deductible or coinsurance.*
2. When the enrollee has no obligation to pay for the use of an organized voluntary ambulance service, donations up to a maximum of $50 for services under 50 miles, $75 for 50 miles or over. *These amounts are not subject to deductible or coinsurance.*

Substitute the following for "O. Prosthetics" under "What is covered ..." in the "Basic Medical Program" section on page 83 of your United HealthCare Certificate.

Prostheses and orthotic devices

Q. **Effective January 1, 2005. Prostheses and Orthotic Devices** – One prosthesis and/or orthotic device per affected body part meeting an individual's functional needs is covered. Replacements when functionally necessary are also covered.

Substitute the following for "R. Hearing Aids" under "What is covered..." in the "Basic Medical Program" section on page 83 of your United HealthCare Certificate.

Hearing aids

T. **Hearing Aids — Effective January 1, 2005.** Hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of $1,200 per hearing aid per ear, once every four years. Children age 12 years and under are eligible to receive a benefit of up to $1,200 per hearing aid per ear, once every two years when it is demonstrated that a covered child's hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child's hearing loss. *These benefits are not subject to deductible or coinsurance.*

Add the following at the end of "What is covered..." in the "Basic Medical Program" section on page 83 of your United HealthCare Certificate.

Mastectomy prostheses

AB. **Effective January 1, 2005. Mastectomy Prostheses** – One single or double mastectomy prosthesis per calendar year is covered in full. Any single external mastectomy prosthesis costing $1,000 or more requires approval through the Home Care Advocacy Program (HCAP). Call HCAP toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose United HealthCare before you purchase the prosthesis. For a prosthesis requiring approval, if a less expensive prosthesis can meet an individual's functional needs, benefits will be available for the most cost-effective choice. *This benefit is not subject to deductible or coinsurance.*

Substitute the following for "Pre-Admission Certification: Hospital" in the "Benefits Management Program" section on page 84 of your United HealthCare Certificate.

Hospital admission

Effective January 1, 2005. If you do not comply with Pre-Admission Certification requirements for hospital admission, you will be subject to paying a $200 hospital deductible. No payment will be made for any day it is determined that your hospitalization is not medically necessary.

Substitute the following for the second paragraph of "A. Durable Medical Equipment" under "HCAP-covered Durable Medical Equipment and Supplies" in the "Home Care Advocacy Program" section on page 85 of your United HealthCare Certificate.

HCAP

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

Substitute the following for the second paragraph of "Infertility Benefits" on page 90 of your United HealthCare Certificate.

Infertility benefits

Infertility benefits, including Qualified Procedures, are subject to the same copayments, deductibles, coinsurance maximums and percentages payable as benefits for other medical conditions under the Participating Provider and Basic Medical programs. Effective January 1, 2005, Qualified Procedures are subject to a $50,000 lifetime maximum.

Substitute the following for "Maximum lifetime benefit" in the "Infertility Benefits" section on page 90 of your United HealthCare Certificate.

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

Substitute the following for the second paragraph under "Infertility Centers of Excellence" in the "Infertility Benefits" section on page 91 of your United HealthCare Certificate.

Infertility Centers of Excellence

When attending an Infertility Center of Excellence for Qualified Procedures more than 100 miles from a patient's residence, benefits are also available for travel, lodging and meal expenses. Reasonable expenses for the patient and one family member companion traveling on the same day to and/or from the center are payable under this infertility benefit. Travel by private automobile will be reimbursed at the Internal Revenue Service per-mile rate in force at the time. Available coach airfare is covered only when the authorized Infertility Center of Excellence is more than 200 miles from a patient's residence. These benefits are available only if the expenses have been pre-authorized by United HealthCare and are applied toward the $50,000 maximum lifetime benefit.

Add the following after "Infertility Benefits" on page 91 of your United HealthCare Certificate.

Centers of Excellence for Cancer Program

Cancer Program

Available October 1, 2004. The Centers of Excellence for Cancer Program provides paid-in-full coverage for cancer-related expenses received through a nationwide network known as Cancer Resource Services (CRS). If you choose to participate in the Centers of Excellence for Cancer Program, you receive enhanced benefits as detailed below. The enhanced benefits include travel reimbursement and a paid-in-full benefit for services covered under the Program and performed at one of the CRS Centers of Excellence. You will also have access to health care nurse consultants who will answer your cancer-related questions and help you understand your cancer diagnosis. Participation in the Centers of Excellence for Cancer Program is voluntary, but the enhanced benefits under the Program are available only when you have enrolled with the Cancer Resource Services and notified your case manager before obtaining services.

Centers of Excellence. Facilities covered under the Centers of Excellence for Cancer Program include some of the best cancer centers in the United States. For a current list of Centers of Excellence for Cancer, call The Empire Plan toll-free number, 1-877-7-NYSHIP (1-877-769-7447) and press or say 1 on the main menu for United HealthCare, then 5 for Cancer Resource Services.

What is covered? You receive paid-in-full benefits for the following services:

- Inpatient and outpatient hospital and physician care related to the cancer treatment and provided by one of the CRS-contracted Centers of Excellence.
- Cancer clinical trials and related treatment and services. Such treatment and services must be recommended and provided by a physician in a cancer center. The cancer center must be a participating facility in the Cancer Resource Services network at the time the treatment or service is given.

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

Enrollment. To receive the paid-in-full benefit and the travel benefit, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447). Press or say 1 on the main menu for United HealthCare and then press or say 5 to connect to Cancer Resource Services to enroll in the Program.

Other benefits still available. The Centers of Excellence for Cancer Program is voluntary. If you choose not to enroll in the Program, you are still eligible for Empire Plan benefits for your covered cancer treatment. Covered medical/surgical services may be available under the Participating Provider Program or the Basic Medical Program through United HealthCare. Covered hospital services may be available through Empire Blue Cross Blue Shield. You also will have to comply with the requirements of The Empire Plan Benefits Management Program and will have to pay any applicable deductible, coinsurance and copayments.

Substitute the following for "A." of "How" and "A." of "When" in the "How, When and Where to Submit Claims" section on page 97 of your United HealthCare Certificate.

Claims: How

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

Claims: When

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

Add the following at the end of "Refund to United HealthCare for overpayment of benefits" in the "Miscellaneous Provisions" section on page 100 of your United HealthCare Certificate.

Recovery of overpayments

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident or due to medical malpractice, and we pay benefits as a result of that injury or illness, we will be subrogated to and shall succeed to all rights of recovery against the party responsible for your illness or injury to the reasonable value of any benefits we have paid. This right is limited to the amount of the settlement that represents medical expenses that have been paid. This means that we have the right, as a plaintiff-intervener in the action you may commence, to proceed against the party responsible for your injury or illness to recover the benefits we have paid. However, we shall not exercise our right to bring an independent action if you do not pursue a claim.

GHI CERTIFICATE OF INSURANCE

Empire Plan Mental Health and Substance Abuse Program

Substitute the following for the second paragraph of "Emergency services" in the "How to Receive Benefits for Mental Health and Substance Abuse Care" section on page 111 of your GHI Certificate as amended in your January 2004 Empire Plan Report.

Emergency services

Effective January 1, 2005. You must pay the first $50 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this $50 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for "d." under "NETWORK COVERAGE" in the "Schedule of Benefits for Covered Services" on page 116 of your GHI Certificate as amended in your January 2004 Empire Plan Report.

Effective January 1, 2005. d. You pay the first $50 charged for emergency care in a hospital emergency room. You will not have to pay this $50 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for "b." under "NETWORK COVERAGE" in the "Schedule of Benefits for Covered Services" on page 116 of your GHI Certificate as amended in your June 2003 Empire Plan Report.

Outpatient rehabilitation program

b. **Effective January 1, 2005.** You pay the first $15 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.

CIGNA CERTIFICATE OF INSURANCE

Empire Plan Prescription Drug Program

Add the following at the end of "J. Brand-Name Drug" under "Meaning of Terms Used" on page 130 of your CIGNA Certificate.

Brand-name drug

*A **Preferred Brand-Name Drug** usually does not have a generic equivalent. A **Non-Preferred Brand-Name Drug** in many cases has a generic equivalent and/or one or more preferred brand-name options.*

Substitute the following for "Copayments..." in the "Your Benefits and Responsibilities" section on page 131 of your CIGNA Certificate.

Copayments

Effective January 1, 2005. When you fill your prescription for up to a **30-day supply at a participating pharmacy or through the Express Scripts Mail Service,** your copayment is:

- **$5** for a **generic** drug
- **$15** for a **preferred brand-name** drug
- **$30** for a **non-preferred brand-name** drug

When you fill your prescription for a **31 to 90-day supply at a participating pharmacy,** your copayment is:

- **$10** for a **generic** drug
- **$30** for a **preferred brand-name** drug
- **$60** for a **non-preferred brand-name** drug

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

- **$5** for a **generic** drug
- **$20** for a **preferred brand-name** drug
- **$55** for a **non-preferred brand-name** drug

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

Substitute the following for "Mandatory Generic Substitution" in the "Your Benefits and Responsibilities" section on page 132 of your CIGNA Certificate as amended in your January 2004 Empire Plan Report.

Mandatory Generic Substitution

When your prescription is written for a brand-name drug that has a generic equivalent, you pay the non-preferred brand-name copayment plus the difference in cost between the brand-name and the generic drug, not to exceed the full cost of the drug.

The following brand-name drugs are excluded from Mandatory Generic Substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid and Tegretol.

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. For an appeal form which you and your doctor must complete, call toll free 1-877-7-NYSHIP (1-877-769-7447) and choose Express Scripts. 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 the applicable. If your appeal is denied, you can make a second appeal to the program insurer.

Substitute the following for "A. Federal Legend Drugs" under "What is covered" in the "Your Benefits and Responsibilities" section on page 133 of your CIGNA Certificate.

Federal Legend drugs

A. Federal Legend Drugs. Drugs or medicines whose labels must bear the legend: RX Only.

Add the following after "F." at the end of "What is covered" in the "Your Benefits and Responsibilities" section on page 133 of your CIGNA Certificate.

On-premises pharmacies

G. Prescription drugs dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility; rest home; sanitarium; extended care facility; convalescent hospital; or similar facility. Such on-premises pharmacies are considered non-participating pharmacies and require submission of a claim form for reimbursement.

Substitute the following for "E." under "Exclusions and Limitations" in the "Your Benefits and Responsibilities" section on page 133 of your CIGNA Certificate.

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

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

Substitute the following for "1." and "3." in the "Coordination of Benefits" section on page 136 of your CIGNA Certificate.

Coordination of benefits

1. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of Coordination of Benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than The Empire Plan's total allowable charge for a service covered under both group plans.
3. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than The Empire Plan's total allowable charge for the service you receive.

2005 Empire Plan Copayments for Employees of New York State Represented by PEF

Services by Empire Plan Participating Providers

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

Office Visit $15

Office Surgery $15

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

Radiology, Single or Series;
Diagnostic Laboratory Tests $15

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

Mammography, according to guidelines $15

Adult Immunizations.....$15

Allergen Immunotherapy .....No Copay

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

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

Chemotherapy, Radiation Therapy,
Dialysis .....No Copay

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

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

Free-standing Cardiac
Rehabilitation Center visit.....$15

Urgent Care Center $15

Contraceptive Drugs and Devices when
dispensed in a doctor's office $15
(in addition to any copayment(s) due for Office Visit/Office Surgery and Radiology/Laboratory Tests)

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

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

Medically appropriate local commercial
ambulance transportation $35

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

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

Office Visit $15

Radiology; Diagnostic Laboratory Tests $15

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

Hospital Outpatient Department Services

Emergency Care.....$50*

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

Network Hospital Outpatient Department Services

Surgery $35*

Diagnostic Laboratory Tests $35*

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

Administration of Desferal for
Cooley's Anemia $35*

Physical Therapy (following related surgery
or hospitalization) $15

Chemotherapy,
Radiation Therapy, Dialysis.....No Copay

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

***Only one** copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The copayment covers the outpatient facility. Provider services may be billed separately. You will not have to pay the facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you, at that time, as an inpatient.

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

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

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

Visit to Outpatient Substance Abuse Treatment Program $15

Visit to Mental Health Professional.....$15

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

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

Inpatient .....No Copay

Empire Plan Prescription Drugs

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

30-day supply at a participating pharmacy or through the Express Scripts Mail Service

Generic Drug $5

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

Non-Preferred Brand-Name Drug $30**

31 to 90-day supply at a participating pharmacy

Generic Drug $10

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

Non-Preferred Brand-Name Drug $60**

31 to 90-day supply through the Express Scripts Mail Service

Generic Drug $5

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

Non-Preferred Brand-Name Drug $55**

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