



GENERAL INFORMATION & BOOK EMPIRE PLAN CERTIFICATE AMENDMENTS

For Employees of the State of New York
represented by **New York State Correctional Officers
and Police Benevolent Association (NYSCOPBA)**
*who are subject to the binding arbitration award
issued on March 21, 2006*

and for their enrolled dependents
and for COBRA enrollees with their benefits

JULY 1, 2006

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

**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.

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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 July 1, 2006. 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 5 of your NYSHIP General Information Book.

Effective July 1, 2006. 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 “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” and the second paragraph “Separate card for each dependent” 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 Blue Shield Inter-Plan Bank Code is YLS. Out-of-State hospital claims submitted with this code will reach the correct Blue Cross and/or Blue Shield plan.

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 July 1, 2006. 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 July 1, 2006**, 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.

Prospective procedure review: MRI

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 pages 46-47 of The Empire Plan Benefits Management Program.

Effective July 1, 2006. If you fail to call and the Empire BlueCross BlueShield 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 BLUECROSS BLUESHIELD
CERTIFICATE OF INSURANCE**

Insert the following under “2.” of “Introduction” on page 50 of your Empire BlueCross BlueShield Certificate.

Network and non-network facilities

Effective July 1, 2006. 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 BlueCross BlueShield Certificate.

Hospital admission

Effective July 1, 2006. If you do not follow the provisions of the Benefits Management Program, Empire BlueCross BlueShield 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 BlueCross BlueShield will apply a \$200 hospital deductible. Effective July 1, 2006, 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 BlueCross BlueShield 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 BlueCross BlueShield 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 BlueCross BlueShield Certificate.

Outpatient MRI

Effective July 1, 2006. If you fail to call the Benefits Management Program and Empire BlueCross BlueShield’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 BlueCross BlueShield Certificate.

Network and Non-Network Benefits

Network and non-network benefits

Effective July 1, 2006. 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 174 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 BlueCross BlueShield 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 BlueCross BlueShield 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 Benefit Programs, then on NYSHIP Online. Select your group and then click on Find a Provider. You can also call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire BlueCross BlueShield.

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

Inpatient hospital care

Effective July 1, 2006. Empire BlueCross BlueShield 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 BlueCross BlueShield 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 BlueCross BlueShield Certificate as amended in your January 2004 Empire Plan Report.

**Outpatient
hospital care**

Effective July 1, 2006. When you receive the services described in the following sections and subject to the limitations in those sections, Empire BlueCross BlueShield will pay for the same services provided to you in the outpatient department of a hospital as Empire BlueCross BlueShield 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 BlueCross BlueShield Certificate as amended in your June 2003 Empire Plan Report.

**Physical
therapy**

Effective July 1, 2006. 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 BlueCross BlueShield. 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 BlueCross BlueShield Certificate.

Chemotherapy

7. Chemotherapy. Empire BlueCross BlueShield 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 page 54 of your Empire BlueCross BlueShield Certificate.

**Copayment
for emergency
care**

Effective July 1, 2006. 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 BlueCross BlueShield Certificate.

**Copayment
for outpatient
hospital
services**

Effective July 1, 2006. 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 BlueCross BlueShield Certificate.

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

- a facility that is accredited as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- certified as a participating skilled nursing facility under Medicare.

Effective July 1, 2006, 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 BlueCross BlueShield Certificate.

1. Hospice organizations. Empire BlueCross BlueShield 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 July 1, 2006, coverage is subject to the network and non-network level of benefits.

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 BlueCross BlueShield Certificate as amended in your June 2003 Empire Plan Report.

Effective July 1, 2006. 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.

Skilled nursing facility

Hospice care

Infertility benefits

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 July 1, 2006. Substitute “\$15 copayment” for “\$10 copayment” wherever the \$10 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 July 1, 2006. 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 July 1, 2006,** you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

Coinsurance maximum

Substitute “\$1,193 for calendar year 2006” 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 BlueCross BlueShield 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 July 1, 2006. 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 July 1, 2006. The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is \$50,000 per covered person under The Empire Plan hospital and medical programs.

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

U. Effective July 1, 2006. 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 after the third paragraph in the “Basic Medical Program” section on page 81 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 2006, the Basic Medical annual deductible for medical services performed and supplies prescribed by non-participating providers is \$322 for the enrollee, \$322 for the enrolled spouse/domestic partner, and \$322 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 July 1, 2006. 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 BlueCross BlueShield explanation of benefits to document the amount of your covered out-of-pocket expense.

Radiology, anesthesiology, pathology

C. Effective July 1, 2006. 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 “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 July 1, 2006. 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, 2006. Hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of \$1,500 per hearing aid per ear, once every four years. Children age 12 years and under are eligible to receive a benefit of up to \$1,500 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 84 of your United HealthCare Certificate.

Mastectomy prostheses

AB. Effective July 1, 2006. 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 July 1, 2006. 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.

HCAP

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.

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.

Infertility benefits

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

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 July 1, 2006, Qualified Procedures are subject to a \$50,000 lifetime maximum.

Substitute the following for “Maximum lifetime benefit” in the “Infertility Benefits” section on page 91 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.

Infertility Centers of Excellence

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.

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.

Cancer Program

Centers of Excellence for Cancer Program

Available July 1, 2006. 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 select United HealthCare, then 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). Select United HealthCare and then 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 BlueCross BlueShield. 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.

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 July 1, 2006. 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 July 1, 2006. 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 July 1, 2006.** You pay the first \$15 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse

Substitute the following for "f" under "NON-NETWORK COVERAGE" in the "Schedule of Benefits for Covered Services" on page 117 of your GHI Certificate.

Lifetime maximum

Effective January 1, 2006. The lifetime maximum benefit for substance abuse care, including alcoholism, under the non-network coverage is \$250,000 for you, the enrollee, and \$250,000 for each of your covered dependents.

July 1, 2006 Empire Plan Copayments for Employees of New York State Represented by NYSCOPBA

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

InpatientNo 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 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 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.