

Keep these amendments with your 2007 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

January 1, 2009

For Active Employees, Retirees, Vesteers and Dependent Survivors, and their Dependents enrolled through **Participating Agencies** with Empire Plan Benefits

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

NYSHIP
New York State Health Insurance Program

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The policies and benefits described in this booklet are established by the State of New York through negotiations with State employee unions and administratively for non-represented groups. Policies and benefits may also be affected by federal and state legislation and court decisions. The Department of Civil Service, which administers the New York State Health Insurance Program (NYSHIP), makes policy decisions and interpretations of rules and laws affecting these provisions.

Where this document differs from your January 1, 2007 *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)

Add the following as the first three bullets of the first paragraph under "3. Your child age 19 or over who is a full-time student" and delete the following paragraphs: the fourth paragraph under "3. Your child age 19 or over who is a full-time student" and the paragraphs entitled Spring student enrolled for fall, "Spring student, enrolled for fall, but does not attend in fall", "Spring student, not enrolled for fall", "Spring student seeking fall admission" and "Withdrawing from school" under "C. Your child age 19 or over who is a full-time student" in the "Who is Eligible" section on page 4 of the General Information Book.

Leaving school before graduation

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

Add the following as the third paragraph under the box in the "Medicare premium reimbursement" section of "Medicare: When you must enroll and coordinating with NYSHIP" on page 28 of your NYSHIP General Information Book.

Medicare Reimbursement

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is a Federal law that requires some people to pay a higher premium for their Medicare Part B coverage based on their income. If you are required to pay an income-related monthly adjustment amount in addition to the standard Medicare Part B premium, you are eligible to be reimbursed for this additional premium by your agency. To claim the additional IRMAA reimbursement, eligible enrollees are required to apply for and document the amount paid in excess of the standard Medicare Part B premium. Contact your agency Health Benefits Administrator for information on how to apply, a list of documents required or questions on IRMAA.

THE EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM

Substitute the following for the last paragraph of “You must call the Benefits Management Program” on page 42 of The Empire Plan Benefits Management Program.

Benefits Management

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for Prospective Procedure Review:

Before having an elective (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA); Computerized Tomography (CT), Positron Emission Tomography (PET) scan or nuclear medicine test unless you are having the test as an inpatient in a hospital. (See “Prospective Procedure Review: MRI” on page 45 for details.)

Substitute the following for “D. Prospective Procedure Review: MRI” under “The Empire Plan Benefits Management Program: Benefits and Your Responsibilities” on page 45 of The Empire Plan Benefits Management Program.

Prospective Procedure Review

D. Prospective Procedure Review

To protect your Empire Plan benefits, you must call The Empire Plan if you or one of your enrolled dependents is scheduled for an elective (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine test unless you are having the test as an inpatient in a hospital.

Call as soon as your doctor suggests one of the above procedures. Call at least two weeks before the scheduled test. If you did not receive at least two weeks notice from your doctor, call The Empire Plan Benefits Management Program immediately. The nurse will make every effort to complete the review prior to your scheduled test. If you do not receive written confirmation from The Empire Plan, call your Benefits Management Program nurse **before** you go ahead with the procedure.

Substitute the following for “MRI” wherever it appears in the “Benefits Management Program”, “Empire BlueCross BlueShield” and “UnitedHealthcare” Certificates.

Benefits Management Program

Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) or Nuclear Medicine tests

EMPIRE BLUECROSS BLUESHIELD CERTIFICATE OF INSURANCE

Copayment

Effective July 1, 2009. Substitute “\$20 copayment” for “\$18 copayment” wherever the \$18 appears in your Empire BlueCross BlueShield Certificate.

Substitute the following for the heading and first sentence of “Outpatient MRI” in the “Benefits Management Program” section on pages 51 and 52 of your Empire BlueCross BlueShield Certificate.

Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests

- If you did not follow the Prospective Procedure Review requirements for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scans or Nuclear Medicine tests and the procedure was performed in the outpatient department of a hospital, Empire BlueCross BlueShield will conduct a medical necessity review.

*Substitute the following for the second paragraph of item B. 2. "The **annual coinsurance maximum**" in the "Network and non-network benefits" on page 53 of your Empire BlueCross BlueShield Certificate.*

Annual coinsurance maximum

Effective January 1, 2009. 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 \$60 copayment, hospital outpatient services are subject to a \$35 copayment and physical therapy services are subject to a \$18 copayment. Once you have paid \$500 in non-network coinsurance, up to an additional \$500 of covered services is reimbursable under the Basic Medical Program (see page 194 of these Empire Plan Amendments).

Substitute the following for the first paragraph and "A. Conditions for skilled nursing facility care." under "Skilled Nursing Facility Care" on page 57 of your Empire BlueCross BlueShield Certificate

Skilled Nursing Facility Care

If Medicare is your primary coverage, The Empire Plan does not provide Skilled Nursing Facility benefits even for short-term rehabilitative care. If The Empire Plan is your primary coverage, benefits are subject to the requirements of The Empire Plan Benefits Management Program.

- A. Conditions for skilled nursing facility care. Empire BlueCross BlueShield will pay for your care in a skilled nursing facility described in Item 2 below when you meet the following conditions:
1. Care in a skilled nursing facility must be medically necessary. Care is medically necessary when it must be furnished by skilled personnel to assure your safety and achieve the medically desired result.
Custodial care, which is care which is primarily assistance with the activities of daily living, is not covered. The Benefits Management Program requirement to call for pre-admission certification applies to skilled nursing facility admissions including transfers from a hospital.
 2. Coverage will only be provided for as long as inpatient hospital care would have been required if care in a skilled nursing facility were not provided. If your care is pre-certified, you, your doctor and the facility will be notified no later than the day before your certification for skilled nursing facility care will cease.
 3. Benefits in a skilled nursing facility are not provided by Empire BlueCross BlueShield if you are eligible to receive primary benefits from Medicare, even if you fail to enroll in Medicare. You are not eligible to receive Empire BlueCross BlueShield benefits if your Medicare benefits for skilled nursing facilities have been exhausted.

Refer to the General Information section of this book for information on primary coverage under Medicare.

Substitute the following for the second paragraph of "What is covered?" under "Centers of Excellence for Transplants Program" on page 59 of your Empire BlueCross BlueShield Certificate.

Transplants Program

When the above services are pre-authorized by Empire BlueCross BlueShield and provided at a Center of Excellence for Transplants facility, you will not have to make any copayments and a travel, lodgings and meal expenses benefit is available to you. The travel and meals benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: meals, auto mileage (personal or rental car), economy class airfare, train fare, taxi fare, parking, tolls and shuttle or bus fare from lodging to the Center of Excellence.

UNITEDHEALTHCARE CERTIFICATE OF INSURANCE

Copayment

Effective January 1, 2009. Substitute "\$20 copayment" for "\$18 copayment" wherever the \$18 appears in the UnitedHealthcare Certificate.

Plan Overview

Substitute the following for the second paragraph under the heading "Basic Medical Program (A Non-Participating Provider)" under "Plan Overview" on page 77 of your UnitedHealthcare Certificate.

You submit claims to UnitedHealthcare. For covered services and supplies, The Empire Plan reimburses you 80 percent of the reasonable and customary charges for covered services and supplies or the scheduled Pharmaceutical Amount for Pharmaceutical Products, or the actual billed charges, whichever is less.

Substitute the following for "Outpatient MRI" in the "Plan Overview" section on page 78 of your UnitedHealthcare Certificate.

Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests

If you have Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scans or Nuclear Medicine tests, that require **Prospective Procedure Review (PPR)** you must comply with PPR requirements. If you do not comply you may be subject to paying a higher share of the cost as explained in the "Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review" section on page 91. If you do not comply with PPR requirements and UnitedHealthcare's review does not confirm that the procedure was medically necessary, you will be responsible for the full charges. Read the "Benefits Management Program" section for complete information.

Meaning of Terms Used

Substitute the following for the first two lines of item N. "Medically Necessary or Medical Necessity" in the "Meaning of Terms Used" section on page 80 of your UnitedHealthcare Certificate.

N. **Medically Necessary or Medical Necessity** means the health care services, supplies and Pharmaceutical Products which are determined by UnitedHealthcare to be medically appropriate and:

Substitute the following for item O. "Covered Medical Expenses" in the "Meaning of Terms Used" section on page 81 of your UnitedHealthcare Certificate.

O. **Covered Medical Expenses** under the Basic Medical portion of this Plan means the reasonable and customary charges for covered medical services performed or supplies prescribed by a doctor or the Scheduled Pharmaceutical Amount for Pharmaceutical Products provided by a doctor, except as otherwise provided below, due to your sickness, injury or pregnancy. A covered medical expense is incurred on the date the service, supply, or Pharmaceutical Product is received by you. In order for a charge to be a covered medical expense, the service, supply or Pharmaceutical Product must be provided by a provider as defined in paragraph C above. Charges for a service, supply or Pharmaceutical Product provided by a person or facility **not** listed in the definition of provider are **not** covered medical expenses.

The fact that a doctor recommends that a service, supply or Pharmaceutical Product be provided by person who is not a provider does not make the charge for that service a covered medical expense, even if the care provided is medically necessary. These services, supplies, and Pharmaceutical Products must be medically necessary as defined in this section. No more than the reasonable and customary charge for medical services and supplies and the Scheduled Pharmaceutical Amount for Pharmaceutical Products will be covered by the Plan. A more detailed description of covered expenses and exclusions follows.

Substitute the following for item 3. in "P. Reasonable and Customary Charge" under "Meaning of Terms Used" on page 81 of your UnitedHealthcare Certificate.

3. the usual charge of other doctors or other providers in the same or similar geographic area for the same or similar service or supply.

Substitute the following for item S. "Coinsurance" in the "Meaning of Terms Used" section on page 81 of your UnitedHealthcare Certificate.

- S. **Coinsurance** means the difference between the reasonable and customary charge or Scheduled Pharmaceutical Amount and the covered percentage under the **Basic Medical** Portion of the Plan. Coinsurance also means the difference between the network allowance and the covered percentage under the **Managed Physical Medicine Program** and the **Home Care Advocacy Program**. You pay the coinsurance.

Substitute the following for item T. 2. "Covered Percentage" under "Meaning of Terms Used" on page 82 of your UnitedHealthcare Certificate.

2. Under the Basic Medical portion of this Plan, the **covered percentage** for covered medical expenses is **80 percent** of the reasonable and customary charge or the Scheduled Pharmaceutical Amount except:
 - a. as provided on page 83 under "Prospective Procedure Review: MRI"; on page 84 under "Home Care Advocacy Program"; on page 89 under "Guaranteed access" for the Managed Physical Medicine Program and on page 89 under "Infertility Benefits"; and
 - b. **Effective January 1, 2009. The covered percentage becomes 100 percent** of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once the coinsurance maximum is met. In calendar year 2009, the coinsurance maximum is \$1,000 for the enrollee, \$1,000 for the enrolled spouse/domestic partner and \$1,000 for all dependent children combined.

This **Basic Medical Coinsurance Maximum** is adjusted on each January 1 in an amount equal to the percentage increase in the medical care component of the Consumer Price Index for Urban Wage Earners and Clerical Workers, all cities (C.P.I.-W.) for the period July 1 through June 30 of the preceding year.

Effective January 1, 2009. The 20 percent coinsurance you pay for yourself, your enrolled spouse/domestic partner and for all dependent children combined for covered services by non-participating providers counts toward each respective **coinsurance maximum**. Copayments for services by participating providers also count. (The copayments do not stop when you reach the coinsurance maximum.)

The annual deductible does not count toward the coinsurance maximum. Any expenses above the reasonable and customary charge or the Scheduled Pharmaceutical Amount do not count. Expenses under the Managed Physical Medicine Program, Mental Health and Substance Abuse Program and Empire BlueCross and BlueShield Hospital Program do not count, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program.

Once the coinsurance maximum is met, covered medical expenses will be reimbursed at 100 percent of the reasonable and customary or Scheduled Pharmaceutical Amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the reasonable and customary or Scheduled Pharmaceutical Amount and any penalties under the benefits management programs.

Add the following at the end of "Meaning of Terms Used" on page 83 of your UnitedHealthcare Certificate.

- CC. **Nuclear Medicine** means a subspecialty of Radiology best used to demonstrate both image and function of a body organ, as well as its anatomy. It has diagnostic capabilities as well as valuable therapeutic applications and uses very small amounts of radioactive substances, or tracers that are attracted to specific organs, bones or tissues, to diagnose or treat disease.

DD. Scheduled Pharmaceutical Amount means:

For covered Pharmaceutical Products, the lower of:

- a. the actual charge for such covered Pharmaceutical Product or
- b. the price of such covered Pharmaceutical Product as set forth in the RED BOOK published by Thomson Reuters. This Pharmaceutical Product pricing information is updated annually on October 1st, UnitedHealthcare will provide specific pricing information to you upon request.

You are responsible for any amount billed by a non-participating provider which exceeds the Scheduled Pharmaceutical Amount, in addition to the annual deductible and coinsurance amounts.

EE. Pharmaceutical Products means FDA approved prescription Pharmaceutical Products administered by a doctor or other provider within the scope of the provider's license. Pharmaceutical Products does not include pharmaceuticals that are dispensed to you by a licensed pharmacy, which are subject to the provisions of your prescription drug program.

Substitute the following for "H. Ambulatory Surgical Center" in "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on pages 84 and 85 of the UnitedHealthcare Certificate.

Outpatient Surgical Locations

H. Effective January 1, 2009. Outpatient Surgical Location – You pay a \$30 copayment for facility charges at a freestanding outpatient surgical location that has an Empire Plan agreement in effect with UnitedHealthcare on the date of your elective surgery. The copayment includes anesthesiology, radiology and laboratory tests performed at the outpatient surgical location on the same day as the surgery. You pay an additional \$30 copayment for pre-operative testing performed on a different day from the surgery. Surgeon's charges are billed separately and covered under either the Participating Provider or Basic Medical Program provisions.

Substitute the following for item R. under "What is covered under the Participating Provider Program" in the Participating Provider Program section on page 86 of your UnitedHealthcare Certificate.

Chronic care

R. Chronic Care – You are covered for chronic care services for chemotherapy, radiation therapy and dialysis. There is no copayment for these chronic care services or for related services rendered during the course of chemotherapy, radiation therapy or dialysis.

Substitute the following for "S. Adult Immunizations" under "What is covered under the Participating Provider Program" section on page 86 of your UnitedHealthcare Certificate.

Adult Immunizations

S. Adult Immunizations – Immunizations for influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chicken pox), and tetanus are covered. Immunization for human papilloma virus (HPV) is covered for females age 19 through 26. Effective January 1, 2009, immunizations for Herpes Zoster (shingles) is covered for enrollees and dependents age 55 or older. Covered adult immunizations are subject to an office visit copayment.

Add the following at the end of "What is covered under the Participating Provider Program" in the "Participating Provider Program" section on page 86 of your UnitedHealthcare Certificate.

Diabetes Education Centers

V. Diabetes Education Centers – If you have a diagnosis of diabetes you are covered for visits for self-management education subject to an office visit copayment.

Basic Medical Program

Substitute the following for the first and third paragraph of "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" under the "Basic Medical Program" on pages 86 and 87 of your UnitedHealthcare Certificate.

You are responsible for the charges billed by a non-participating provider, and must submit a claim for benefits due.

These benefits are calculated based on the following:

- First, you are liable for the deductible. It is your responsibility.
- After the deductible, covered medical expenses are considered for payment. UnitedHealthcare will reimburse you for 80 percent of the reasonable and customary charges for covered services and supplies or the Scheduled Pharmaceutical Amount, for Pharmaceutical Products, or actual billed charges whichever is less. You pay the balance of 20 percent (coinsurance) and any charges above the reasonable and customary or Scheduled Pharmaceutical Amount. The covered percentage becomes 100 percent of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once each coinsurance amount exceeds the coinsurance maximum in a calendar year.

Add the following as the fourth paragraph of "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" in the "Basic Medical Program" section on page 87 of your UnitedHealthcare Certificate.

You are responsible for the payment of all deductible and coinsurance amounts payable to a non-participating provider after processing of your Basic Medical claim by UnitedHealthcare. Waiver of deductible and co-insurance amounts by a non-participating provider is not permitted under the Basic Medical Program. Prior to receiving services under the Basic Medical benefit you should discuss with your non-participating provider this requirement and your potential "out of pocket" liability. The level of benefits you are entitled to is predicated on meeting all deductible and coinsurance requirements set forth in this Certificate of Insurance. The Plan reserves the right to recover from enrollees benefits paid inconsistent with the provisions of this section of the Certificate of Insurance.

Substitute the following for the first sentence of "A. Annual Deductible" in the "Basic Medical Program" section on page 87 of your UnitedHealthcare Certificate.

Annual deductible

Effective January 1, 2009. For calendar year 2009, the Basic Medical annual deductible for medical services performed and supplies prescribed by non-participating providers is \$363 for the enrollee, \$363 for the enrolled spouse/domestic partner, and \$363 for all dependent children combined.

Substitute the following for item "B. Coverage" and "C. Covered Basic Medical Expenses" in "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" under the "Basic Medical Program" on page 87 of your UnitedHealthcare Certificate.

B. Coverage

UnitedHealthcare will pay **Basic Medical benefits** to the extent covered medical expenses in a calendar year **exceed the deductible and coinsurance, up to the reasonable and customary or the Scheduled Pharmaceutical Amount.**

C. Covered Basic Medical Expenses

Covered medical expenses are defined as the reasonable and customary charge for covered medical services performed or supplies prescribed by a doctor or the Scheduled Pharmaceutical Amount for Pharmaceutical Products provided by a doctor, except as otherwise provided below, due to your sickness, injury or pregnancy. These services, supplies and Pharmaceutical Products must be medically necessary as defined under the Meaning of Terms Used in this Certificate. No more than the reasonable and customary charge or the Scheduled Pharmaceutical Amount for medical services, supplies, and Pharmaceutical Products will be covered by this Plan.

Substitute the following for item B. "Non-network Hospital Program expenses" under "What is covered..." in the "Network and non-network benefits" section under the "Basic Medical Program" on page 88 of your UnitedHealthcare Certificate.

Non-network Hospital, Skilled Nursing Facility and Hospice Care Facility Out-of-Pocket Program Expenses

B. Effective January 1, 2009. 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 \$500 in 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 UnitedHealthcare for reimbursement of up to an additional \$500 of covered charges for non-network hospital, skilled nursing facility or hospice facility care. 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 threshold for reimbursement.** You must provide UnitedHealthcare with a copy of your Empire BlueCross BlueShield explanation of benefits to document the amount of your covered out-of-pocket expense.

Add the following at the end of "What is covered under the Basic Medical Program (non-participating providers" in the "Basic Medical Program" section on page 90 of your UnitedHealthcare Certificate.

Prosthetic Wigs

CC. Effective January 1, 2009, Prosthetic Wigs – Prosthetic wigs are covered up to the \$1,500 lifetime benefit maximum when hair loss is long term and due to a medical condition. These conditions include: disease of the endocrine glands, generalized systemic disease, systemic poisons and hair loss due to radiation therapy, chemotherapy treatment or injury to the scalp. *This benefit is not subject to deductible or coinsurance.*

Prosthetic wigs are **not** covered when hair loss is due to male or female pattern baldness.

Diabetes Education Centers

DD. Diabetes Education Centers – If you have a diagnosis of diabetes you are covered for medically necessary visits for self-management.

Substitute the following for "Prospective Procedure Review MRI" in the "Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review" section on page 91 of your UnitedHealthcare Certificate.

Prospective Procedure Review

Prospective Procedure Review MRI, MRA, CT, PET and Nuclear Medicine tests

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for Prospective Procedure Review before having an elective (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine tests unless you are having the test as an inpatient in a hospital.

If you do not call The Empire Plan before an elective (non-emergency) procedure and UnitedHealthcare's review does not confirm that the procedure was medically necessary, you will be responsible for the full charges.

You do not have to call before an emergency procedure. When UnitedHealthcare receives the claim for the procedure and no call was made, UnitedHealthcare will determine whether the procedure was performed on an emergency basis and whether the procedure was medically necessary.

If you do not call The Empire Plan before a procedure and UnitedHealthcare determines that the procedure was performed on a scheduled (non-emergency) basis and that the procedure was medically necessary, you are liable for the payment of the lesser of 50 percent of the scheduled amounts related to the procedure or \$250, plus your copayment, under the Participating Provider Program.

Under the Basic Medical Program, you are liable for the lesser of 50 percent of the reasonable and customary charges related to the procedure or \$250. In addition, you must meet your Basic Medical annual deductible and you must pay the coinsurance and any provider charges above the reasonable and customary amount.

Add the following as "F. Diabetic Shoes" under "Network coverage: Paid in full benefit" in the "Home Care Advocacy Program" section on page 93 of your UnitedHealthcare Certificate.

Diabetic Shoes

F. Diabetic Shoes – You are covered for one pair of medically necessary custom molded or depth shoes per calendar year if you have a diagnosis of diabetes and diabetic foot disease; diabetic shoes have been prescribed by your provider; and the shoes are fitted and furnished by a qualified podiatrist, orthotist, prosthetist or podiatrist. Shoes ordered by mail or from the internet are not eligible for benefits.

Network coverage - If you use an HCAP-approved provider for medically necessary diabetic shoes you receive a paid-in-full benefit up to a maximum annual benefit of \$500 per year. You must make a pre-notification call to HCAP to receive paid-in-full network benefits.

Non-network coverage - If you do not use an HCAP-approved provider for medically necessary diabetic shoes Basic Medical benefits apply subject to deductible with any remaining covered charges covered at 75 percent of the network allowance with a maximum annual benefit of \$500.

Substitute the following for the second paragraph of "What is covered?" under "Centers of Excellence for Cancer Program" on page 99 of your UnitedHealthcare Certificate.

Cancer Program

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 (200 miles for airfare) from the patient's home, a travel and meals benefit is available to the patient and one travel companion. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: meals, auto mileage (personal or rental car), economy class airfare, train fare, taxi fare, parking, tolls and shuttle or bus fare from lodging to the Center of Excellence.

Exclusions *In all instances where the terms "services and/or supplies", "services or supplies" or "services" are used, replace them, respectively, with "services, supplies and/or Pharmaceutical Products", "services, supplies or Pharmaceutical Products", and "services or Pharmaceutical Products" in the "Exclusions" section of "UnitedHealthcare General Provisions" on pages 100 and 101 of your UnitedHealthcare Certificate.*

Substitute the following for items A. and C. in the "Coordination of Benefits" section of "UnitedHealthcare General Provisions" on page 102 of your UnitedHealthcare Certificate.

Coordination of Benefits

- A. 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 reasonable and customary charge for a service or the Scheduled Pharmaceutical Amount for Pharmaceutical Products covered under both group plans.
- C. 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 reasonable and customary charge for the service or the Scheduled Pharmaceutical Amount or Pharmaceutical Product you receive.

Substitute the following for the second paragraph of item A. in the "Impact of Medicare on this Plan" section of "UnitedHealthcare General Provisions" on page 95 of your UnitedHealthcare certificate.

Medicare

When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations rather than the Participating Provider Scheduled Allowances, the Reasonable and Customary Charge or the Scheduled Pharmaceutical Amount as defined in the Meanings of Terms used.

Add the following as item F. under "Coverage" in the "Impact of Medicare on this Plan" section on page 105 of your UnitedHealthcare Certificate.

Medicare Coverage

- F. ***If you or your dependents are eligible and enrolled for coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.***

EMPIRE PLAN MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

Effective January 1, 2009. Substitute "UnitedHealthcare Insurance Company of New York" for "Group Health Incorporated and "UHIC-NY" for "GHI" wherever these terms appear in the Mental Health Substance Abuse Certificate in your January 2008 Empire Plan Report.

Substitute "OptumHealth" for "ValueOptions" wherever the term appears in the Mental Health Substance Abuse Certificate in your January 2008 Empire Plan Report.

Copayment

Effective July 1, 2009. Substitute "\$20 copayment" for "\$18 copayment" wherever the \$18 appears in the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Substitute the following for the last paragraph of "You will receive non-network coverage for covered services when:" under "Overview" on page 162 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Overview

If you have questions about The Empire Plan Mental Health and Substance Abuse Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-334-1897.

Meaning of Key Terms

Substitute the following for item N. "GHI" in "Meaning of Key Terms" on page 164 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

- N. **UHIC-NY** means UnitedHealthcare Insurance Company of New York, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.

Substitute the following for item EE. "ValueOptions" in "Meaning of Key Terms" on page 166 of your Mental Health and Substance Abuse Certificate in you January 2008 Empire Plan Report.

- EE. **Program** means The Empire Plan Mental Health and Substance Abuse Program. This Program provides coverage under Group Policy No. 715116 issued to the State of New York, the policyholder, by UHIC-NY.

Substitute the following for item KK. "ValueOptions" in "Meaning of Key Terms" on page 167 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

KK. **OptumHealth Behavioral Solutions** (also referred to as OptumHealth) is the company selected by the State of New York to administer The Empire Plan Mental Health and Substance Abuse Program. OptumHealth provides services for UnitedHealthcare Insurance Company of New York in the administration of this Program.

Substitute the following for the first two sentences of item A. under "NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE" on page 172 of the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Coinsurance maximum

Effective January 1, 2009. For Practitioners Services: Up to 80 percent of reasonable and customary charges for covered services after you meet the annual deductible for outpatient practitioner services which is \$363 per enrollee, \$363 per covered spouse/domestic partner and \$363 for all covered dependents combined. The covered percentage becomes 100 percent of the reasonable and customary charge for covered services once the coinsurance maximum is met. There is a separate coinsurance maximum of \$1,000 for the enrollee, \$1,000 for the enrolled spouse/dependent partner and \$1,000 for all dependent children combined.

Substitute the following for item B. under "NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE" on page 172 of the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

- B. For Approved Facility Services: Up to 90 percent of billed charges for covered services. After an annual coinsurance maximum of \$1,500 for you, the enrollee, \$1,500 for your enrolled spouse/domestic partner and \$1,500 for all enrolled dependent children combined is met. Each coinsurance maximum is applied as follows:
1. You pay the first \$500 of coinsurance, then
 2. The Program reimburses you for the next \$500 of coinsurance, upon written request of the enrollee, then
 3. You pay the final \$500 of coinsurance.

Medicare Coverage

Delete the last sentence of the first paragraph of item A. and add the following as item F. as the last item under "Coverage" in the "Impact of Medicare on this Plan" section on page 179 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

- F. **If you or your dependents are eligible and enrolled for primary coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.**

Substitute the following for the second paragraph under the heading "How" in the "How, When and Where to Submit Claims" section on page 180 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

How

If you use non-network coverage, you must submit a claim. You may obtain a claim form from:

OptumHealth Behavioral Solutions
P.O. Box 5190
Kingston, NY 12402-5190

or

You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

Substitute the following for "Where" in the "How, When and Where to Submit Claims" section on page 181 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an "Explanation of Medicare Benefits" form to: OptumHealth Behavioral Solutions, P.O. Box 5190, Kingston, NY 12402-5190.

Substitute the following for the first paragraph of "Appeals: 60-day deadline" in the "Appeals" section on page 183 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Appeals

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 60 days after you receive a notice of denial of the certification or claim to:

OptumHealth Behavioral Solutions
Attn: BH Appeals Dept.
900 Watervliet Shaker Road, Suite 103
Albany, NY 12205-1002

Empire Plan Prescription Drug Program

Substitute the following for "Copayments..." in the "Your Benefits and Responsibilities" section on page 140 of your Empire Plan Prescription Drug Program Certificate.

Copayments

Effective January 1, 2009. When you fill your prescription for a **30-day supply at a participating pharmacy or through the Mail Service Pharmacy**, your copayment is:

- **\$5** for a **generic** drug
- **\$15** for a **preferred brand-name** drug
- **\$40** 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
- **\$70** for a **non-preferred brand-name** drug

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

- **\$5** for a **generic** drug
- **\$20** for a **preferred brand-name** drug
- **\$65** for a **non-preferred brand-name** drug

July 1, 2009 Empire Plan Copayments for Participating Agencies with Empire Plan Benefits

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 UnitedHealthcare 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..... \$20

Office Surgery..... \$20

(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..... \$20

(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 \$20

Adult Immunizations \$20

Allergen Immunotherapy No copayment

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

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

Chemotherapy, Radiation Therapy,
Dialysis..... No copayment

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

Hospital-based Cardiac
Rehabilitation Center No copayment

Free-standing Cardiac
Rehabilitation Center visit..... \$20

Urgent Care Center \$20

Contraceptive Drugs and Devices when
dispensed in a doctor's office \$20
(in addition to any copayment(s) due for Office
Visit/Office Surgery and Radiology/Laboratory Tests)

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

Outpatient Surgical Locations (including
Anesthesiology and same-day pre-operative
testing done at the center)..... \$30

Medically appropriate local
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 UnitedHealthcare at 1-877-7-NYSHIP (1-877-769-7447) toll free. Internet: www.cs.state.ny.us.

Office Visit..... \$20

Radiology; Diagnostic Laboratory Tests..... \$20

(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 \$60 *

(The \$60 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) \$20

Chemotherapy, Radiation Therapy, Dialysis No copayment

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

***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 (MRI), Magnetic Resonance Angiography (MRA); Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine tests.

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

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

Visit to Outpatient Substance Abuse Treatment Program \$20

Visit to Mental Health Professional \$20

Psychiatric Second Opinion when Pre-Certified No copayment

Mental Health Crisis Intervention (three visits) No copayment

Inpatient No copayment

Empire Plan Prescription Drugs

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

Up to a 30-day supply from a participating retail pharmacy or through the Mail Service Pharmacy

Generic Drug \$5

Preferred Brand-Name Drug \$15

Non-Preferred Brand-Name Drug \$40**

31- to 90-day supply from a participating retail pharmacy

Generic Drug \$10

Preferred Brand-Name Drug \$30

Non-Preferred Brand-Name Drug \$70**

31- to 90-day supply through the Mail Service Pharmacy

Generic Drug \$5

Preferred Brand-Name Drug \$20

Non-Preferred Brand-Name Drug \$65**

**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.