

Keep these amendments with your September 1, 2003 New York State Health Insurance Program General Information Book and Empire Plan Certificate. Pages in your Book/ Certificate and later Certificate Amendments have consecutive numbers.



GENERAL INFORMATION & BOOK EMPIRE PLAN CERTIFICATE AMENDMENTS

For the BCI Unit of the New York State Police represented by the **Police Investigators Association** and for their enrolled Dependents and for COBRA enrollees with their benefits

JANUARY 2009

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

New York State Health Insurance Program General Information Book

Leaving school before graduation.....	223
When your Family coverage begins.....	223
Health Care Spending Account.....	223
Medicare Reimbursement.....	223

Empire Plan Benefits Management Program

Benefits Management.....	224
Prospective Procedure Review.....	224
Benefits Management Program.....	224

Empire Plan Certificate Amendments

Empire BlueCross BlueShield

Copayment.....	225
Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests	225
Annual coinsurance maximum.....	225
Skilled Nursing Facility Care	225
Transplants Program.....	226

UnitedHealthcare

Copayment.....	226
Plan Overview	226
Outpatient MRI, MRA, CT, PET and Nuclear Medicine tests	226
Meaning of Terms Used.....	227
Outpatient Surgical Locations	229
Chronic care	229
Adult Immunizations.....	229
Diabetes Education Centers	229
Basic Medical Program	229
Annual deductible	230
Non-network Hospital Program expenses.....	230
Prosthetic Wigs	231
Diabetes Education Centers	231
Prospective Procedure Review.....	231
Diabetic Shoes	232
Cancer Program	232
Exclusions	232
Coordination of Benefits	232
Medicare	233
Medicare Coverage	233

Empire Plan Mental Health and Substance Abuse Program

Copayment.....	233
Overview	233
Meaning of Key Terms	233
Coinsurance maximum	234
Medicare Coverage	234
How	234
Where	234
Appeals.....	235

Empire Plan Prescription Drug Program

Copayments	235
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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 September 1, 2003 *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 21 (or 19 if enrolled in an HMO) or over who is a full-time student” and delete the following paragraphs: the fourth paragraph under “3. Your child age 21 (or 19 if enrolled in an HMO) 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 21 (or 19 if enrolled in an HMO) or over who is a full-time student” in the “Eligibility” section on pages 5 and 6 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.

Substitute the following for the second paragraph under “When your Family coverage begins” in the “Coverage Individual or Family” section on page 9 of your NYSHIP General Information Book as amended in the September 2005 Amendments.

When your Family coverage begins

If you and a spouse or domestic partner each have individual coverage in NYSHIP and you change to one Family coverage, there is no waiting period.

Substitute the following for “Another money-saving program” in the “Costs, Pre-Tax Program and What Your Paycheck Stub Shows” section on page 14 of your NYSHIP General Information Book.

Health Care Spending Account

Also ask for information on the **Health Care Spending Account**, a flex spending benefit that allows you to set aside pre-tax dollars to pay for medically necessary health related expenses that are not reimbursed by your health insurance or any other benefit plan. For more information and annual enrollment deadlines you can go to www.flexspend.state.ny.us.

Substitute the following for “Medicare premium reimbursement” and “Reimbursement for dependents not automatic” in the “Medicare: When you must enroll and coordinating with NYSHIP” section on page 35 of your NYSHIP General Information Book.

Medicare Reimbursement

Medicare premium reimbursement

If you or your dependent is Medicare primary, The State will reimburse you for the usual (base) cost of “original” Medicare Part B monthly premiums unless you are receiving reimbursement from another source.

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 NYSHIP.

Retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions, COBRA enrollees and covered spouses/domestic partners who become Medicare primary at age 65 are automatically reimbursed for Medicare Part B premium. Enrollees and covered dependents who become Medicare primary before age 65 because of disability or end stage renal disease must apply for reimbursement. You must take a photocopy of your dependent's Medicare identification card to your agency Health Benefits Administrator. Be sure to include your name and identification number on the photocopy. If you are not an active employee, contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344.

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.

For information on how to apply, a list of documents required or questions on IRMAA, you may call the Employee Benefits Division at 457-5754 (if you are located in the 518 area code) or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

THE EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM

Substitute the following for the last paragraph of "You must call the Benefits Management Program" on page 43 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 46 for details.)

Substitute the following for "4. Prospective Procedure Review: MRI" under "The Empire Plan Benefits Management Program: Benefits and Your Responsibilities" on page 46 of The Empire Plan Benefits Management Program.

Prospective Procedure Review

4. 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.

Benefits Management Program

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

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

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 2. B. “The **annual coinsurance maximum**” in the “Network and non-network benefits” on page 52 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.

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 an \$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 230 of these Empire Plan Amendments).

Substitute the following for the first paragraph and “1. Conditions for skilled nursing facility care.” under “Skilled Nursing Facility Care” on page 55 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.

1. 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:

- A. 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.

- B. Coverage will only be provided for as long as inpatient hospital care would have been required if care in a skilled nursing facility were not provided. If your care is pre-certified, you, your doctor and the facility will be notified no later than the day before your certification for skilled nursing facility care will cease.
- C. 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 57 of your Empire BlueCross BlueShield Certificate as amended in the January 2007 Amendments.

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 July 1, 2009. *Substitute “\$20 copayment” for “\$18 copayment” wherever the \$18 appears in the UnitedHealthcare Certificate.*

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.

Plan overview

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 75 of your UnitedHealthcare Certificate.

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

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 76. 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 a 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 \$800 for the enrollee, \$800 for the enrolled spouse/domestic partner and \$800 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**. 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 as the last item under "Meaning of Terms Used" on page 79 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 “G. Ambulatory Surgical Center” in “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 81 of the UnitedHealthcare Certificate.

Outpatient Surgical Locations

G. **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 82 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 “F. Adult Immunizations” under “What is covered under the Participating Provider Program” section on page 81 of your UnitedHealthcare Certificate as amended in your January 2007 Empire Plan Report.

Adult Immunizations

F. **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 82 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.

Substitute the following for the first 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.

Basic Medical Program

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 second 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 83 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 83 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 84 of your UnitedHealthcare Certificate as amended in your September 2005 Empire Plan Report.

Non-network Hospital 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 Blue Cross Blue Shield 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 86 of your UnitedHealthcare Certificate.

Prosthetic Wigs

AC. **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

AD. **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 86 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 “6. Diabetic Shoes” under “Network coverage: Paid in full benefit” in the “Home Care Advocacy Program” section on page 89 of your UnitedHealthcare Certificate.

Diabetic Shoes

6. **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 175 of the January 2007 amendments to 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 99 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 and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Substitute “OptumHealth” for “ValueOptions” wherever the term appears in the Mental Health and 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 196 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.

Substitute the following for item N. “GHI” in “Meaning of Key Terms” on page 198 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Meaning of Key Terms

- 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. “Program” in the “Meaning of Key Terms” on page 200 of your Mental Health and Substance Abuse Certificate in your 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 202 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.

Coinsurance maximum

Substitute the following for the first two sentences of item A. under “NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE” on page 208 of the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

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 \$800 for the enrollee, \$800 for the enrolled spouse/dependent partner and \$800 for all dependent children combined.

Substitute the following for item B. under “NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE” on page 208 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.

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 216 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Medicare Coverage

- 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 217 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 218 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.

Appeals

Substitute the following for the first paragraph of “Appeals: 60-day deadline” in the “Appeals” section on page 219 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

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 133 of your Empire Plan Prescription Drug Program Certificate as amended in your January 2007 Empire Plan Report.

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 Employees of New York State Represented by PIA

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 <i>and</i> 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.