NYSHIP
New York State Health Insurance Program

General Information Book & Empire Plan Certificate

For Active Employees
of **Participating Employers**
and for their enrolled dependents
and for COBRA enrollees with their benefits

August 1, 2001

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

New York State Health Insurance Program General Information Book

Empire Plan Certificate

Benefits Management Program

Empire Blue Cross and Blue Shield

United HealthCare

GHI/ValueOptions
Mental Health and Substance Abuse Program

CIGNA/Express Scripts
Prescription Drug Program

Symbol on front cover:
You must call first to receive maximum level of benefits. Please read these sections carefully. The inside back cover has a list of numbers to call and a brief summary of calling requirements.

New York State Health Insurance Program
General Information for Active Employees of Participating Employers and their Dependents Enrolled in the Empire Plan
and for COBRA Enrollees with their benefits

This book explains your rights and your responsibilities as an enrollee in the New York State Health Insurance Program (NYSHIP). Please review this information and share it with members of your family.

The policies and benefits described in this book 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 NYSHIP, makes policy decisions and interpretations of rules and laws affecting these provisions. In addition, the Participating Employer establishes certain provisions. Therefore, the policies and benefits described in this book are subject to change as a result of those processes. You will be notified of changes by mailings to your home.

About This Book

This book has two parts: Your **New York State Health Insurance Program (NYSHIP) General Information Book** and your **Empire Plan Certificate of Insurance**. It combines previous documents. It replaces your 1995 NYSHIP General Information Book and all Empire Plan Reports and Certificate Amendments updating that book.

Be sure you are eligible; receipt of this book does not guarantee you are eligible or enrolled for coverage.

Be sure you have the right book. This book is for Active employees of NYSHIP Participating Employers and their dependents and COBRA enrollees, covered under the Empire Plan. A NYSHIP Participating Employer is a government agency in New York State that is maintained and financed from special administrative funds and participates in NYSHIP. There is a different book for retirees, vestees and dependent survivors enrolled through Participating Employers and their enrolled dependents. If you need a different book, contact your agency Health Benefits Administrator.

Save this book and all subsequent Empire Plan Reports and Certificate Amendments. New books are not issued every year. Supplements will be sent to you if benefits change. It is important that you read and keep this book and future Empire Plan Reports and Certificate Amendments that update this book and inform you of important changes to your NYSHIP coverage.

Identification Cards. Use your New York Government Employee Benefit Card when you go to a hospital, participating provider, or participating pharmacy. New cards are not issued every year.

If You Need Assistance

If you want information on your enrollment, eligibility, benefit card or any other aspect of the New York State Health Insurance Program, **contact your agency Health Benefits Administrator (HBA), usually in the Human Resources (Personnel) Office.** See *"Directory"*, page 136. COBRA enrollees: Contact the Employee Benefits Division (see inside back cover).

You are responsible for letting your agency know of any changes that may affect your coverage. See *"Keeping Your Coverage Up to Date"* on page 30. COBRA enrollees: Contact the Employee Benefits Division.

You may also visit our Web site at *http://www.cs.state.ny.us* (Click on Employee Benefits).

For questions on specific benefits or claims, call the appropriate carrier (see inside back cover). Please have your health insurance identification number (usually your Social Security number) ready when you call.

August 1, 2001

State of New York, Department of Civil Service, Employee Benefits Division
The State Campus, Albany, New York 12239
http://www.cs.state.ny.us

GIB-EMPIRE PLAN/PE/8-01

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NYSHIP General Information Book

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Empire Plan Certificate

Overview of the New York State Health Insurance Program (NYSHIP)

Valuable benefits, choice of plans

You are among the 1.1 million enrollees and dependents who make the New York State Health Insurance Program (NYSHIP) one of the largest group health insurance programs in the United States. NYSHIP provides valuable medical benefits for you and your eligible dependents through two different options: The **Empire Plan**, an indemnity plan with some managed care features, or health care from a participating **Health Maintenance Organization (HMO)** in your area. Both options provide medical and surgical care, hospital expense benefits, mental health and substance abuse benefits. Both options also provide prescription drug coverage when it is not available through a union Employee Benefit Fund.

Coverage not automatic

If you are eligible for NYSHIP, you may enroll in the option of your choice. But enrollment is not automatic; you must file an enrollment form with your agency Health Benefits Administrator.

Your employer pays most of your premium

You may choose Individual coverage for yourself only or Family coverage for yourself and your eligible dependents. For most enrollees, the Participating Employer helps you pay the cost of your health insurance premium. You pay the balance, which is deducted from your paychecks.

Identification cards

Empire Plan enrollees and their enrolled dependents each receive an identification card to present to hospitals, providers and pharmacies when receiving services. (If you receive prescription drug coverage from a union Employee Benefit Fund, you will receive a separate prescription drug card.)

After NYSHIP eligibility ends

Under certain circumstances, you may be able to continue your NYSHIP coverage when your payroll status changes (for example, if you are on leave without pay or laid off). Many retirees, vestees, and dependent survivors are also eligible to continue NYSHIP coverage. If your eligibility for NYSHIP coverage ends, under certain circumstances you may be able to continue benefits for a specified period under a federal continuation law (COBRA) or by converting to a direct-pay contract with the Empire Plan's hospital or medical carrier(s).

Your Health Benefits Administrator

The Employee Benefits Division in the Department of Civil Service works with the Health Benefits Administrator in each agency to process transactions and help you with your health insurance questions. You are responsible for notifying your agency Health Benefits Administrator of any changes that might affect your enrollment. See *"Directory,"* page 136.

The above is a quick overview. For more information, read the following pages carefully.

Your Options Under NYSHIP

The options

To enroll for health insurance coverage, you will need to decide which option you want: the Empire Plan or a Health Maintenance Organization (HMO) that has been approved for participation in NYSHIP in the geographic area where you live or work. However, HMOs approved for participation in NYSHIP may not be available in all areas.

The benefits provided by the Empire Plan and the HMOs differ. Be sure to weigh your needs and choose the option that provides the most suitable coverage.

The Empire Plan

The Empire Plan is a health insurance program that pays for covered hospital services, physicians' bills, and other covered medical expenses.

What the Empire Plan provides

The Empire Plan provides to enrollees and eligible dependents:

- Hospital and related benefit coverage through Empire HealthChoice, Inc., doing business as Empire Blue Cross and Blue Shield;

- Medical/surgical benefits through United HealthCare Insurance Company of New York (United HealthCare) for a modest copayment when you use participating providers;
- Basic Medical coverage through United HealthCare when you receive medical/surgical coverage from non-participating providers;
- Home Care Advocacy Program and Managed Physical Medicine Program through United HealthCare;
- Mental Health and Substance Abuse Program through Group Health Incorporated (GHI)/ValueOptions;
- Prescription drug coverage through CIGNA/Express Scripts unless your prescription drug coverage is provided through a union Employee Benefit Fund; and
- Benefits Management Program through Intracorp for hospital and skilled nursing facility admissions, Prospective Procedure Review, Medical Case Management and High Risk Pregnancy Program.

A Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) provides health care services which are fully covered except for copayments and coinsurance. To enroll in an HMO participating in NYSHIP, you must live or work within that HMO's NYSHIP geographic service area. Except for emergency services, you and your enrolled dependents must receive services from your HMO's physicians or at health centers or hospitals affiliated with the HMO unless you have made other arrangements with your HMO.

What HMOs provide

Each HMO provides a specific package of benefits. Each provides to you and your eligible dependents:

- Hospitalization and related expense coverage;
- Medical/surgical care, including coverage for mental health and substance abuse. Some HMOs provide services at group medical facilities; others do so through contracts with independent physicians; and
- Prescription drug coverage when it is not provided through a union Employee Benefit Fund.

Annual Option Transfer Period

During the annual Option Transfer Period, usually in November, you may change your health insurance option for any reason. You may change from an HMO to the Empire Plan, or from the Empire Plan to an HMO or from one HMO to another HMO in your area.

Each year you will be notified of the Option Transfer Period dates through your agency Health Benefits Administrator or a mailing to your home. Option transfer information is also available on the Internet at http://www.cs.state.ny.us. Check deadlines and consider your options carefully.

To change options during the Option Transfer Period, see your agency Health Benefits Administrator. Your employer will notify you of your share of the premium.

Changing options *outside* the Option Transfer Period

You may change options outside the designated Option Transfer Period **only** under the following circumstances:

- You are enrolled in an HMO and you move permanently out of your HMO's service area. You **must** change options in order to keep your NYSHIP coverage. You may change to an HMO approved for participation in NYSHIP in your new area, or you may change to the Empire Plan.
- You move to a new permanent address and your new home area is served by an approved HMO that did not serve your previous home area. You may change to the new HMO regardless of what option you were in before you moved.
- You have a job change and want to change to an HMO that was not available where you previously lived or worked.
- You have a job change out of the NYSHIP service area of the HMO in which you were enrolled.
- You return to the State payroll after military leave.

- You return to the State payroll after a break in service, if you were ineligible to continue enrollment during the break.
- You return to the State payroll after going on leave without pay. If you canceled your health insurance and missed an Option Transfer Period during the leave, you have 30 days after your return to the payroll to change your option.
- You are assigned a new State service anniversary date following a break in service.
- You retire and do not live in the HMO's service area but are enrolled in the HMO because you worked in the HMO's service area.
- You are an HMO enrollee covered under a prescription drug program provided by an Employee Benefit Fund and you lose eligibility for that coverage because of a change in negotiating unit. You may change options when the negotiating unit change takes place.
- Your dependent experiences an unforeseen change in permanent residence and is no longer in your HMO's service area. (Note: A student attending college outside your HMO's service area is not considered to have made a change in permanent residence.)

Your dependents' option

You and your dependents will have the same option. You, as the enrollee, will determine their option. There is one exception: A spouse or dependent child who continues health insurance coverage under the federal COBRA law may elect an option different from yours during the Option Transfer Period, or when moving under the circumstances described above. (See *"COBRA: Continuation of Coverage"* page 24.)

Examples of option transfer requests that are turned down

Q. My doctor no longer participates in the option I selected. May I change to another option?

A. Not until the annual Option Transfer Period.

Q. I'm going to retire next month. May I change options?

A. Not until the annual Option Transfer Period, unless you meet one of the specific conditions listed above.

Q. My wife needs an operation right away. We would like a different group of doctors to take care of her. May I change options so her surgery will be covered?

A. Not until the annual Option Transfer Period, unless you meet one of the specific conditions listed above.

Q. My child has just been diagnosed with a chronic condition requiring an expensive brand-name drug. Since I will be filling prescriptions for this medication regularly for a long time, my out-of-pocket costs will be high. May I change to another option where my cost for this prescription will be lower?

A. Not until the annual Option Transfer Period.

Consider carefully

Be sure you understand how your benefits will be affected by changing options. You are choosing a benefit package for yourself and your dependents for the program year, January through December. By changing options, you could be getting substantially different coverage.

Who is Eligible?

This section explains eligibility requirements under NYSHIP for you (the enrollee) and your dependents.

You, the enrollee

To be eligible for coverage, you must be appointed or elected to a position with a Participating Employer and:

1. Be an unpaid board member of a public authority with at least six months service as a board member

or

2. Be expected to work at least six biweekly payroll periods. If you are hired as a seasonal employee, you must be expected to work at least six months.

and

3. Work at least half-time on a regular schedule or be an elected official or a paid member of a public legislative body. However, if you are working at a public educational institution (such as a public school, college or university) while pursuing a degree there, you must work full-time.

and

4. Be on the payroll at the time you enroll. If you begin work, then take an unpaid leave of absence, you are not eligible until you return to the payroll and complete any waiting period established by your employer, including days worked before your leave began.

and

5. Not already be enrolled in NYSHIP as an employee. If you are covered under the program **as a dependent** of your spouse, and you are eligible for your own coverage in NYSHIP, see *"Two types of coverage"* on page 8.

Your dependents

The following dependents are eligible for NYSHIP coverage:

1. Your spouse

Your spouse, including a legally separated spouse, is eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage. If your marriage ends, you must notify your agency Health Benefits Administrator and end coverage for your spouse, effective the date the marriage ends. Your spouse may be able to continue coverage under COBRA (see *"COBRA"* on page 24).

Or your domestic partner

Ask your agency Health Benefits Administrator if your Participating Employer offers coverage for domestic partners. Under this provision, you may cover your same or opposite sex domestic partner as your dependent under NYSHIP. A domestic partnership, for eligibility under NYSHIP, is one in which you and your partner are 18 years of age or older, unmarried and not related in a way that would bar marriage, living together, involved in a lifetime relationship and financially interdependent. To enroll a domestic partner, you must have been in the partnership for one year and be able to provide proof of residency and financial interdependence. Agency Health Benefits Administrators have complete information on eligibility, enrollment procedures and coverage dates.

To cover your domestic partner's child, the standard NYSHIP provisions for adding a dependent apply. (See *"Other children"* in paragraph 2 below. Note that waiting periods may apply when you enroll a dependent more than seven days after eligibility.)

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health insurance benefits is treated as income for tax purposes. The employee's extra cost for domestic partner coverage cannot be paid with pre-tax dollars. Ask your tax consultant how enrolling your domestic partner will affect your taxes.

If the partnership ends, you must notify your agency Health Benefits Administrator and end coverage for the domestic partner. Your domestic partner may be able to continue coverage under COBRA (see *"COBRA"* on page 24).

There will be a two-year waiting period from the termination date of your previous partner's coverage before you may again enroll a domestic partner.

Employees who fraudulently enroll a domestic partner are held financially and legally responsible for any benefits paid and are subject to disciplinary action. Such employees will forfeit future coverage.

If you die, your surviving domestic partner may be eligible to continue in NYSHIP; however, coverage will end if he or she marries or acquires a domestic partner. (If your surviving *spouse* acquires a domestic partner and your spouse is otherwise eligible, your spouse may continue coverage in NYSHIP, but may not cover the domestic partner.) See *"Coverage for Your Dependent Survivors"*, page 22, to determine whether your partner is eligible.

Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare-eligible due to disability, NYSHIP is primary.

In other respects, throughout the General Information Book, coverage for domestic partners and spouses is the same.

2. Your child under age 19

Your unmarried children under 19 years of age are eligible. This includes your natural children, legally adopted children, including children in a waiting period prior to finalization of adoption, and your dependent stepchildren. Other children who reside permanently with you in your household who are chiefly dependent on you and for whom you have assumed legal responsibility in place of the parent also are eligible; you must verify eligibility and provide documentation upon enrollment and every two years thereafter.

3. Your child age 19 or over who is a full-time student

Your unmarried dependent children who are age 19 or over but under age 25 are eligible if they are **full-time** students at an accredited secondary or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage. They continue to be eligible until the earlier of the following dates:

- The end of the third month following the month in which they complete course requirements for graduation; or
- They reach age 25.

For children other than your natural children, legally adopted children or dependent stepchildren, support by you as described in paragraph 2 must have commenced before the child reached age 19.

If your child reaches age 19 during a school vacation period, coverage will continue, as long as the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution and plans to resume classes on a full-time basis at the end of the vacation period. Proof of enrollment may be required.

Students who want to continue health insurance coverage during the summer must have been enrolled in the previous spring semester and must be enrolled as full-time students for the fall semester.

Note: NYSHIP rules for dependent students continuing coverage during summer vacation between the spring and fall semesters also apply to dependent students continuing coverage during a winter vacation between the fall and spring semesters.

Spring student, enrolled for fall A dependent child who is a full-time student in the spring semester and enrolled as a full-time student for the fall, and attends school in the fall, continues coverage under the parent's policy during the summer.

Spring student, enrolled for fall, but does not attend in fall When a dependent child who was enrolled in the spring semester and for the following fall semester will not be returning to school full-time for the fall semester, coverage under the parent's policy will terminate on the last day of the month in which the enrollee notifies the agency Health Benefits Administrator that the student will not be continuing as a full-time student.

If the enrollee notifies the agency Health Benefits Administrator after classes start in the fall, NYSHIP eligibility ends on the first day of classes of the fall semester; proof of the first day of classes may be requested.

Students who were enrolled for fall but do not attend must provide proof of enrollment in the previous spring semester, such as a grade transcript or tuition receipt. If proof is not provided, coverage as a dependent student under the parent's policy will terminate on the last day of the month in which the child was a full-time student.

Spring student, not enrolled for fall If a dependent child who was a full-time student in the spring semester does not enroll as a full-time student for the fall semester, coverage under the parent's policy will end on the last day of the month in which the student was a full-time student attending classes.

Entering school When an enrollee applies for dependent student coverage for a dependent child who is not currently a student, coverage will begin on the first day of the month in which attendance in class actually starts.

Withdrawing from school When a dependent student withdraws from school after classes have begun for the semester, coverage will end on the last day of the month in which the dependent attended classes as a full-time student.

Reduced course load If a dependent child who is enrolled as a full-time student voluntarily drops a course and becomes a part-time student, coverage will end on the last day of the month in which the dependent child was considered a full-time student. If a dependent child becomes a part-time student because the school has canceled a course and the dependent child cannot register in another course to continue full-time status, coverage as a dependent student will continue through that semester as if the dependent child was a full-time student.

Ask your agency Health Benefits Administrator if COBRA, the federal Consolidated Omnibus Budget Reconciliation Act, applies to your agency.

Partially disabled students

A partially disabled dependent student between the ages of 19 and 25 taking a reduced course load that is the maximum for that student's capability is eligible; you must provide medical documentation.

Medical leave for students age 19 or over

If your child is granted a medical leave by the school, health insurance coverage will continue for a maximum of one year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester. You must be able to provide written documentation from the school and doctor.

Military service

For purposes of eligibility for health insurance coverage as a student dependent, you may deduct from your dependent's age up to four years for service in a branch of the U.S. Military. You must be able to provide written documentation from the U.S. Military.

4. Certain students completing graduation requirements

Your unmarried dependent children who are age 19 or over but under age 25 who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:

A. Otherwise qualify;

and

B. Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed;

and

C. Be able to provide a statement from their school or college administrator which verifies the student's status. They continue to be entitled to benefits for up to three months following the end of the month in which they complete course requirements for graduation. At the end of the three months, the graduated student will have 60 days to apply to the Employee Benefits Division for COBRA continuation of coverage, if COBRA applies to your agency. A dependent child may be granted a second semester of coverage during part-time attendance if there are unusual, extenuating circumstances, which, through no fault of the student, prevent that student's timely graduation. Requests for this continued coverage must be submitted in writing to the Employee Benefits Division.

5. Disabled dependents: 60-day deadline

Your unmarried dependent children age 19 or over who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for health insurance are eligible. For example, if your child becomes disabled at age 19 or older while covered as a full-time dependent student, the child may qualify to continue coverage as a disabled dependent.

If you have a child who is enrolled in NYSHIP and qualifies for coverage as a disabled

dependent, you must provide medical documentation. If you anticipate eligibility on this basis, you must file a Disability Form PS-451. Contact your agency Health Benefits Administrator as soon as possible after enrollment, even if your child is under the age when eligibility would normally terminate through age disqualification. The deadline for filing Disability Form PS-451 is 60 days after the child's 19th birthday.

However, if your disabled dependent child was not enrolled in NYSHIP because the child had other health insurance, and loses the other coverage involuntarily, you may apply for disabled dependent child coverage. For your application to be considered, you must file a Disability Form PS-451 within 60 days of the loss of other coverage. You must provide proof that the disability occurred prior to NYSHIP's standard age disqualification date and the loss of other coverage was involuntary.

If your child who is age 19 or over but under age 25 is covered as a full-time student, and is disabled or becomes disabled while a full-time student, contact your agency Health Benefits Administrator as soon as possible. The deadline for filing Disability Form PS-451 is 60 days after the child loses NYSHIP coverage.

Proof of eligibility

All new enrollees and dependents must provide proof of eligibility to enroll in NYSHIP. Your application to enroll or to add a dependent to your coverage will not be processed unless accompanied by satisfactory documentation. Providing false or misleading information about eligibility for coverage or benefits is considered fraud.

Questions?

Under certain circumstances, you may be able to re-enroll a dependent who regains eligibility after a period of ineligibility. Please read *"Re-enrolling a dependent"* on page 8.

Active employees: If you have any questions concerning eligibility, please contact your agency Health Benefits Administrator. COBRA enrollees: Contact the Employee Benefits Division.

Enrollment

Enrollment is not automatic

If you are eligible for NYSHIP and you decide you want to be covered, you must sign up for coverage and select either the Empire Plan or a Health Maintenance Organization (HMO). You will not be covered automatically.

You must apply

To enroll for coverage, you must file Form PS-404 with your agency Health Benefits Administrator. If you choose an HMO, you must also file an HMO Enrollment Form which your agency will mail to the HMO.

If you or a dependent whom you wish to enroll is covered by another group insurance plan, you must complete a Coordination of Benefits Form PS-600.

When coverage begins

Your Participating Employer establishes the date on which an employee becomes eligible for NYSHIP. This is the First Date of Eligibility. It may be as early as the first day of employment or it may be one month later. Ask your Health Benefits Administrator for information specific to your agency.

There may be a **waiting period** between your First Date of Eligibility and the date on which your coverage goes into effect depending on **when you apply** for coverage. If you apply:

- **on or before** the First Date of Eligibility, coverage begins on that date.
- **within 30 days** after the First Date of Eligibility, coverage begins on the first day of the month following your application.
- **more than 30 days** after the First Date of Eligibility, coverage begins on the first day of the third month following your application.

No coverage during waiting period

Medical expenses incurred or services rendered during your waiting period will not be covered. Be sure to keep any other insurance you may have, if possible, to cover medical or hospitalization expenses until your NYSHIP coverage becomes effective.

How to cancel enrollment

To cancel your enrollment in NYSHIP, see your agency Health Benefits Administrator.

When coverage ends

Coverage ends on the last day of the month if your employment ends on or before the 15th day of that month. Coverage ends on the last day of the following month if your employment ends after the 15th day of the month.

Certificate of Coverage dates

If you or your dependent loses Empire Plan coverage, Empire Blue Cross and Blue Shield will automatically mail you a Certificate of Coverage under the Empire Plan. This certificate will state the beginning and ending dates of your or your dependent's Empire Plan coverage period. You will receive a certificate if you change your health insurance option under NYSHIP, if your COBRA coverage ends, if your insurance is canceled for non-payment during leave without pay, or if you lose your coverage for any other reason. If you lose your health insurance coverage, you may need the Certificate of Coverage to reduce the length of a pre-existing condition exclusion in a new plan outside NYSHIP.

Re-enrolling a dependent

Dependents who lose eligibility because of marriage, loss of student status, or loss of disabled dependent status may be eligible to reenter NYSHIP if they subsequently become divorced, widowed or re-enroll in school, provided they are otherwise eligible. Unmarried disabled dependents may also reenter NYSHIP if they have a relapse of the same disability which qualified them as disabled dependents while they were in NYSHIP and which again renders them incapable of self-support. (COBRA enrollees: A dependent child who becomes disabled during COBRA status is not eligible to re-enroll in NYSHIP as a disabled dependent under the parent's policy.) The only circumstance in which a dependent survivor may reenter NYSHIP after losing eligibility due to marriage is annulment of the marriage. To reenroll, you must be able to provide documentation.

Coverage: Individual or Family

Two types of coverage

Two types of coverage are available to you under NYSHIP:

- **Individual Coverage** provides benefits for you only. It does not cover your dependents even if they are eligible for coverage.
- **Family Coverage** provides benefits for you and your eligible, enrolled dependents. To enroll yourself and your dependents in Family coverage, you must provide each person's date of birth, Social Security number (if one is assigned) and other information to NYSHIP through your agency Health Benefits Administrator.

If you and your spouse are each eligible for your own coverage in NYSHIP:

- You may have one Family coverage, or
- You may each have Individual coverage, or
- You may each have Family coverage if your employer permits two Family enrollments: however, if one spouse is a State employee, you can have only one Family enrollment. If the spouse who works for a Participating Employer chooses Family coverage, the spouse who is a State employee may elect Individual coverage.

Changing from Individual to Family coverage

If you qualify for a change from Individual to Family coverage and you want Family coverage, contact your agency Health Benefits Administrator. You may request this change at any time you qualify; you do not need to wait until the Option Transfer Period.

When your Family coverage begins

The date your Family coverage begins will depend on your reason for changing and your **promptness** in applying. You can avoid a waiting period by applying promptly.

If you and a dependent each have Individual coverage in NYSHIP and you change to one Family coverage, there is no waiting period.

If you change to Family coverage as the result of one of the following events:

- You acquire a new dependent (for example, you marry). Note: The time frame for covering newborns is different. See *"Coverage for Newborns"* below.
- Your spouse's other health insurance coverage ends.
- You return to the payroll after military leave and you want to cover dependents acquired during your leave.

*Then, your new coverage begins according to **when** you apply:*

- If you apply **not more than seven days after** the event, your Family coverage will be effective on the date the dependent(s) was first eligible.
- If you apply **more than seven days but within 30 days after** the event, there will be a waiting period. Your Family coverage will become effective on the first day of the month following the month in which you apply.
- If you apply **more than 30 days after** the event, there will be a longer waiting period. Your Family coverage will become effective on the first day of the third month following the month in which you apply. If you apply on the first day of the month, that month is counted as part of the waiting period.

No coverage during waiting period

Services received or expenses incurred by your dependent(s) during this waiting period will not be covered.

Coverage for newborns: You have 30 days

If you want to change from Individual coverage to Family coverage to cover a newborn child from the date of birth, you have 30 days from the child's birth to request this change.

If you are adopting a newborn, you must establish legal guardianship as of the date of birth or file a petition for adoption under Section 115(c) of the Domestic Relations Law no later than 30 days after the child's birth.

Considered late if previously eligible

If you change to Family coverage in order to include your spouse/domestic partner or dependents who were previously eligible but unenrolled, their coverage will begin according to the late enrollment schedule described in *"Changing to Family Coverage"* on page 10.

Exception for new dependent

However, an exception is made if you acquire a new dependent during the late enrollment waiting period after you apply for a change to Family coverage. (For example, if your child is born during the waiting period, the child will be eligible for benefits under your Family coverage beginning with the date of the child's birth.) This exception is not automatic. You must contact your agency Health Benefits Administrator for this benefit.

Exception for court order

If you are subject to a court order mandating that dependents be enrolled immediately in employer health insurance, the late enrollment waiting period will be waived for your eligible dependents covered by the court order. You must provide a copy of the court order and any supporting documents needed to show that the dependents are covered by the order and eligible for coverage under NYSHIP eligibility rules. You must contact your agency Health Benefits Administrator for this benefit.

Add newborn to existing Family coverage

If you have Family coverage, remember to add your newborn child within 30 days, or you may encounter claim payment delays. Your child is not automatically covered. You must contact your agency Health Benefits Administrator within 30 days to complete the appropriate forms and to provide a copy of the birth certificate. If you have not yet received a Social Security number for the child, remember to provide a copy of the child's Social Security card as soon as you receive it.

Changing to Family Coverage

If you want to change to Family coverage because (for example):

You marry or your domestic partner becomes eligible
You have or adopt a child
You acquire other dependent children
You return from military leave
Your spouse's or domestic partner's other insurance ends

And you apply...	Their coverage begins...
Within 7 days of the event	On the day dependent(s) was first eligible.
Within 30 days after the birth or adoption of a newborn	On the date of birth.
More than 7 days but within 30 days of the event	On the day you apply if that day is the first day of a month. Otherwise, on the first day of the next month.
More than 30 days after the event	On the first day of the third month following the month in which you apply.
More than 30 days after the birth or adoption of a newborn	On the first day of the third month following the month in which you apply.

Canceling coverage for your enrolled dependent(s)

You **must** cancel coverage for your dependent when he or she is no longer eligible. See your agency Health Benefits Administrator and read the COBRA chapter in this book.

Changing from Family to Individual coverage

You **must** change to Individual coverage when you no longer have **any** eligible dependents.

You may choose to change from Family to Individual coverage at any time if you no longer wish to cover your dependents, even though they are still eligible.

Contact your agency Health Benefits Administrator for information about when your dependents' coverage ends if you change from Family to Individual coverage.

Identification Cards

Your card

Your Empire Plan identification card, called a New York Government Employee Benefit Card, is a plastic card similar to a bank or credit card. You will receive your New York Government Employee Benefit Card after your enrollment in the Empire Plan is processed. Keep your list of Empire Plan telephone numbers with your card.

Separate card for each dependent

If you have Family coverage, you will also receive a separate card for each covered dependent.

How to use your card

Use your card when you go to a hospital, Empire Plan Participating Provider, MPN Network Provider, ValueOptions Network Provider, or Express Scripts Participating Pharmacy. Present your New York Government Employee Benefit Card **before** you receive services. (If you receive prescription drug coverage from a union Employee Benefit Fund, you will receive a separate prescription drug card.)

No expiration date

There is no expiration date on your card because the computer database is continually updated to reflect any changes in your enrollment status. You will use this card as long as you remain in the Empire Plan.

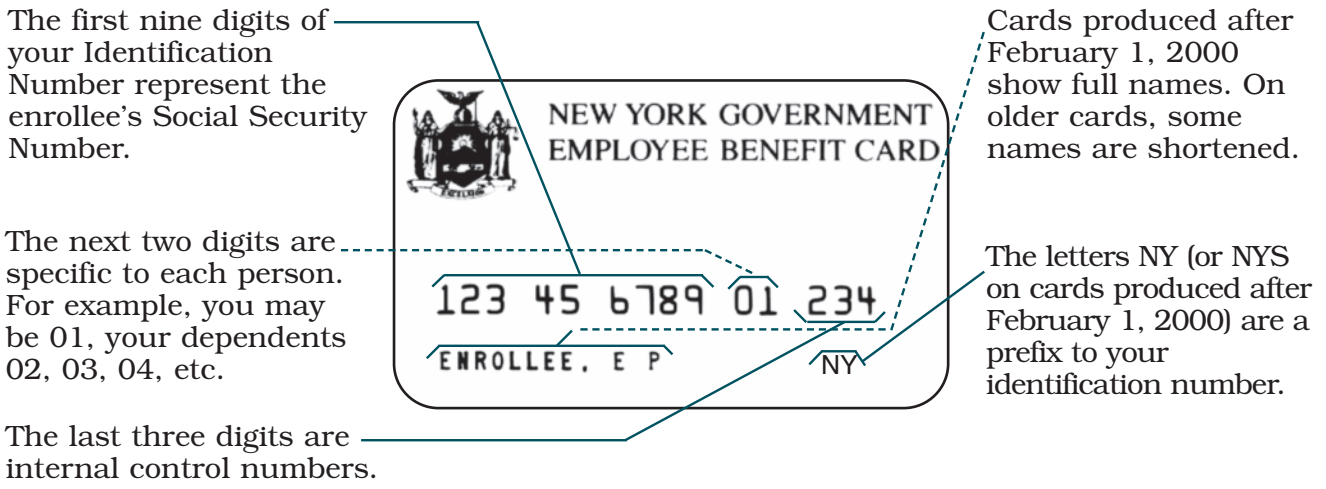
Replacing your card

Ask your agency Health Benefits Administrator to order a replacement card if your card (or a dependent's) is lost or damaged.

Don't use your card after eligibility ends

Remember, you are responsible for notifying your agency Health Benefits Administrator promptly when you or your dependents are no longer eligible for NYSHIP coverage. If you or your dependent uses the card when no longer eligible for benefits, you will be billed for all expenses you or your dependents incur after eligibility ends. Use of the card after eligibility ends constitutes fraud.

Sample New York Government Employee Benefit Card for Empire Plan Enrollees



The Blue Cross Inter-Plan Bank Code is YLS. This code appears on replacement cards and cards of new enrollees, enrollees who reside out-of-State and enrollees who submit claims from an out-of-State hospital. **Out-of-State hospital claims submitted with this code will reach the correct Blue Cross plan.**

Cost

Your share of the premium

Your employer helps employees pay for health insurance coverage. After your employer's contribution, you pay the balance of your premium, if any, through deductions from your paychecks.

Your employer pays at least 50 percent of the cost for Individual coverage. If you have Family coverage, your employer pays at least 50 percent of the cost for Individual coverage plus at least 35 percent of the additional cost for dependent coverage.

Ask your agency Health Benefits Administrator for the premium rates for the Empire Plan and HMOs. Rates effective at the beginning of the program year are announced during the annual Option Transfer Period, usually in November. Rates are also available on the Internet at http://www.cs.state.ny.us.

COBRA enrollees: There is no employer contribution toward your premium.

Note: Payment of premium does not establish eligibility for benefits. You must satisfy NYSHIP eligibility requirements. (See *"Who is Eligible?"* on page 3.)

Waiver of premium

In certain situations, you may be entitled to have your health insurance contribution waived for up to one year. The Empire Plan provides a waiver of premium when authorized. However, most HMOs do not provide a waiver of premium. If you enroll in an HMO, check with your agency Health Benefits Administrator before you file for a waiver.

To qualify for a waiver, you must meet **all** three of the following requirements:

1. You must have been totally disabled as a result of sickness or injury, on a continuous basis, for a minimum of three months;

   and

2. You must be on authorized leave without pay, unpaid Family and Medical Leave or covered under Preferred List provisions. You are not eligible for the waiver if you are still receiving income through salary, sick leave accruals or retirement allowance;

   and

3. You kept your coverage in effect while you were off the payroll by paying the required full cost of your health insurance premium (your contribution and the employer's contribution) if you are on leave without pay, or by paying the employee share if you are covered under Family and Medical Leave or Preferred List provisions.

Waiver is not automatic

A waiver of premium is **not** automatic. You must apply for it, and you must continue to pay your health insurance premiums until you are notified that the waiver has been granted. You will receive a refund for any overpayments.

Waiver ends if...

The waiver may continue for up to one year during your period of total disability **unless:**

- You return to the payroll
- You are no longer covered under leave without pay, Family and Medical Leave or Preferred List provisions
- You are no longer disabled
- You are separated from the service of an agency that participates in NYSHIP and are not covered under Preferred List provisions
- The agency that employs you no longer participates in NYSHIP
- You vest your health insurance coverage rights
- You retire
- You die

How to apply for a waiver of premium

To apply for a waiver of premium, obtain Form PS-452 from your agency Health Benefits Administrator. After you, your agency and your physician have filled in the required information, return the completed form to:

Employee Benefits Division
State of New York Department of Civil Service
The State Campus
Albany, New York 12239

You must apply during the period in which you meet the eligibility requirements for a waiver; you may not apply after you return to the payroll or vest or retire.

The Employee Benefits Division will notify you if your waiver has been granted.

Additional waiver of premium

If you received a waiver of premium for up to one year, you must return to work before being eligible for an additional waiver of premium. If you have not returned to work, you may not use accruals to return to the payroll for a brief period in order to qualify for an additional waiver.

If you receive a waiver of premium, return to work and continue health insurance coverage, but must stop working due to a disability, the following rules apply:

- If you must stop working after less than three months, you may resume coverage under the previous waiver for the remainder of the original one-year period which includes the time back to work.
- If you stop working after three or more consecutive months, you may apply for a new waiver of premium for an additional one-year period.

There is no lifetime limit to the number of waivers you may receive. The Employee Benefits Division will notify you if an additional waiver has been granted.

How Changes in Your Status Affect Coverage

Special circumstances, such as changes in your payroll status, may affect your enrollment. Make sure that your health insurance coverage is correct. Consult your agency Health Benefits Administrator when your work or payroll status changes.

Leave without pay

If you are on authorized leave without pay, or otherwise leave the State payroll temporarily, you may be eligible to continue your health insurance coverage while you are off the payroll.

Continuing coverage when on leave is not automatic

Coverage while you are on leave for more than 28 days is not automatic. Before going on leave without pay, you must choose to continue coverage or cancel coverage during the period of leave without pay. You must also choose whether you want to resume coverage after you return to the payroll.

If you are going on leave because of military duty or under the Family and Medical Leave Act, special provisions may apply.

Family and Medical Leave Act

Under the Family and Medical Leave Act (FMLA) of 1993, a federal law, eligible workers are entitled to up to 12 weeks of unpaid leave in a 12-month period for certain family and medical reasons. During the Family and Medical Leave, you may continue health insurance and other benefits at the employee share of the premium. You have the right to apply for health insurance waiver of premium during the FMLA period (see *"Waiver of premium"* on page 11). Ask your agency Health Benefits Administrator if this leave is available to you and how you may continue your health insurance.

Military leave

If you are on voluntary military leave of 31 days or less, you pay only the employee share of the premium to continue Family coverage. If you are on voluntary military leave that is longer than 31 days, you pay both the employer and employee shares to continue Family coverage. If you are a member of an Armed Forces Reserve or a National Guard Unit called to active duty by a declaration of the President of the United States or an Act of Congress, your covered dependents will be eligible for up to 12 months of Family coverage at no cost to you. You must have had Family coverage for at least 30 days before your activation. If the active duty continues beyond 12 months, you must pay both the employer and employee shares of the premium to continue Family coverage.

Your coverage while on leave for more than 28 days is not automatic. Before going on military leave (or any leave without pay), you must arrange for coverage through your agency Health Benefits Administrator.

If you do not continue your coverage during military leave, you may reinstate coverage without any waiting period when you return to work. However, exclusions may apply if you have service-related medical problems or conditions.

Cost

To continue your health insurance coverage while on leave, in most cases, you must pay both the employee and employer shares of the premium. If you become disabled while you are on leave, you may be eligible for a Waiver of Premium (see *"Waiver of Premium"* on page 11).

Your agency will notify you of your monthly cost and the due dates for your payments. If you do not make your payments on time, your coverage will be canceled and you will not be offered conversion privileges.

Suspending or canceling coverage while off the payroll

You may suspend or cancel your health insurance coverage for the time you are on leave without pay or Family and Medical Leave. Make arrangements with your agency Health Benefits Administrator before your last day of work. You will not be required to submit any premium payments. Your coverage will end on the last day of the month in which you request suspension or cancellation.

Cancellation for nonpayment of premium

If you do not voluntarily suspend or cancel your health insurance coverage, and you do not make premium payments, your health insurance coverage will be canceled on the last day of the last month for which you were paid.

Consider the consequences

Suspending or canceling your coverage or letting it lapse because you don't pay the premium is a serious step. If you resign, vest or retire while your coverage is suspended or canceled, you and your dependents have no rights to coverage under NYSHIP. If you die and you had suspended or canceled your coverage or let it lapse, your dependents have no rights to coverage as dependent survivors or under COBRA provisions.

You may re-enroll *before* you return to work

If your coverage was suspended or canceled while you were on leave and you want to reinstate your coverage **before** you return to work, you may ask to be reinstated, subject to the late enrollment provision. Contact your agency Health Benefits Administrator.

You may re-enroll *when* you return to work

If your coverage was suspended or canceled while you were on leave, you may re-enroll in NYSHIP when you return to work, provided you still meet the eligibility requirements (see *"Who is Eligible?"* on page 3). Contact your agency Health Benefits Administrator to reactivate your coverage. Be sure to get written confirmation of when your coverage will begin because you may be subject to a late enrollment waiting period.

You may re-enroll if you become eligible for FMLA

If your coverage was canceled while you were on leave and then you have a qualifying event for health insurance under the Family and Medical Leave Act, you may reactivate your coverage at the employee share for the FMLA period. You must have had coverage in effect while in active status immediately prior to the leave. Coverage will begin at the start of the FMLA period, and you must pay for coverage based upon that starting date. When you reactivate coverage, whether during the FMLA leave or upon return to work, there is no late enrollment waiting period.

Abolition of position and Preferred List

Coverage continues for a year

If your job is abolished, ask if your employer offers coverage under Preferred List Provisions. If your name has been placed on a Preferred List, you may continue your health insurance coverage for up to one year or until you are re-employed in a benefits-eligible position by a public or private employer, whichever occurs first. If you are not eligible to be placed on Preferred List for re-employment but are separated from service because your position was abolished, you may be permitted to continue your coverage under Preferred list provisions. If your appointment was a permanent appointment, you are eligible to continue health insurance under Preferred List provisions.

If your Participating Employer offers Preferred List coverage, you are required to pay only the employee's share of the premium during this time. Check with your agency Health Benefits Administrator for information about possible changes in your health insurance benefits.

COBRA extends coverage

After a year, or when your coverage ends, if you are not eligible for health insurance in vestee or retiree status, you may be eligible to continue coverage under COBRA. See *"COBRA"* on page 24.

Contact your agency Health Benefits Administrator if you have any questions about how a change in your status may affect your health insurance coverage.

Continuing Coverage When You Retire

Eligibility for retiree coverage

When you retire, you may continue coverage for yourself and your eligible dependents if you meet certain requirements. The benefits may differ somewhat from those you receive as an active employee. Your agency Health Benefits Administrator can provide information about health insurance benefits for retirees.

Note: Ask your Participating Provider if your class (group) of employees is eligible to continue health insurance in retirement. Then, read this information carefully. Retirement System requirements for pension benefits are different from NYSHIP requirements for continuing health insurance as a retiree or vestee. For example, part-time service is not counted the same way for health insurance as it is counted for State-administered retirement benefits. **Do not assume that your health insurance benefits will continue automatically when you retire.** Also, if you are eligible but do not want your coverage to continue when you retire, you must contact your agency Health Benefits Administrator.

A Participating Employer's responsibility to provide health insurance coverage for its retirees is determined, in part, by whether the agency's effective date of participation in NYSHIP is before March 1, 1972, or on or after that date.

Prior to March 1, 1972

If your agency elected to participate in NYSHIP **prior to March 1, 1972,** you must meet the following three eligibility requirements in order to continue your health insurance coverage:

1. Complete the minimum service period

First, you must have had at least five years of service, not necessarily continuous, with your agency from which you are retiring, subject to the following:

- Your agency may elect administratively or through collective negotiations to establish a service requirement greater than five years for purposes of determining eligibility for retirement for all employees or a class or category of employees whose most recent date of employment with the employer is after April 1, 1975.
- If you had less service than that established by your agency for coverage in retirement, your agency may elect administratively or through collective negotiations to provide for continuation of coverage in retirement for all employees or a class or category of employees who have met the applicable period of required service with one or more public employers, provided you have served a minimum of one year with your agency.
- If your agency elects to provide retiree coverage, it will do so for all employees or all employees in a class or category who meet the conditions specified. Your agency may elect administratively or through collective negotiations to establish as ineligible for coverage all employees or a class or category of employees whose most recent date of employment with the employer is after April 1, 1977.

Less than full-time employment: Periods of less-than-full-time employment will be considered as full-time if you were eligible for health insurance. Periods of employment in which you did not meet the eligibility requirements will not be counted. Periods when you were paying both the employer share and employee share of the NYSHIP premium while on leave without pay do not count toward the minimum service requirement.

2. Satisfy requirements for retiring as a member of a retirement system

Second, you must be qualified for retirement as a member of a retirement system administered by New York State (such as the New York State and Local Employees' Retirement System, the New York State Teachers' Retirement System, or the New York State and Local Police and Fire System) or any of New York State's political subdivisions. Be sure to check with your retirement system as part of your retirement planning.

If you are not a member of a retirement system administered by the State, you must satisfy one of the following conditions:

- You must meet the age requirement of the Employees' Retirement System retirement tier in effect at the time you last entered service, or
- You must be qualified to receive Social Security disability payments.

3. Be enrolled in NYSHIP

Third, you must be enrolled in NYSHIP as an enrollee or a dependent at the time of your retirement. For example, if you were on leave and canceled your coverage, and then retire, you may not be eligible for health insurance as a retiree.

On or after March 1, 1972

If your agency elected to participate in NYSHIP **on or after March 1, 1972,** you are eligible to continue coverage in retirement if you are a member of a class or category of employees for which your agency has elected administratively or through collective bargaining agreements to provide coverage in retirement. You must also have met requirements 1, 2, and 3 above.

Remember to contact your agency Health Benefits Administrator to discuss your coverage in retirement and to have your status changed from "active" to "retired."

Note: If you retire but delay collecting your State pension, you may continue your NYSHIP coverage under retiree provisions, provided you meet the eligibility requirements listed above. You will make monthly premium payments directly to the Employee Benefits Division or to your former Participating Employer. Ask your agency Health Benefits Administrator about "constructive retirement."

Re-enrolling as a retiree

After you retire, you may cancel coverage, then re-enroll. Under most circumstances you will be subject to a waiting period before your coverage again becomes effective. Any sick leave credits will be maintained on your record until you reactivate your enrollment.

Disability retirement

Ordinary disability retirement: For an ordinary (not work-related) disability retirement, the age requirement is waived, but you must meet the minimum service requirement.

Work-related disability retirement: For a disability retirement resulting from a work-related illness or injury, the age requirement and the minimum service requirement are waived.

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

Deadline: If you have not continued your coverage while on leave or in vestee or COBRA status and a retroactive retirement is granted. Call your agency Health Benefits Administrator to ask about reinstating coverage. Call as soon as you have the decision on your disability retirement. You must apply in writing for reinstatement of your NYSHIP coverage **within 60 days** of the date on the letter from your retirement system announcing the decision to grant your disability retirement. If coverage is reinstated for an ordinary disability retirement, you will be required to pay premiums retroactively.

How you pay

When you retire, you will pay your share of the health insurance premium, if any, through deductions from your monthly retirement check or by making monthly payments directly to the Employee Benefits Division or to your former Participating Employer. It may take several months for the Employee Benefits Division to receive the Retirement Number assigned to you by the Retirement System, and begin taking monthly health insurance deductions from your pension. Meanwhile, you will be billed directly each month for your share of the premium. Be prepared to make these payments each month until pension deductions begin.

Sick leave credits

You may be entitled to use the value of your accumulated unused sick leave to offset all or part of the cost of your health insurance during retirement whether you are in the Empire Plan or an HMO. This will not affect the value of your sick leave for pension purposes.

Lifetime monthly credit

When you retire, your unused sick leave is converted into a dollar amount by dividing the total dollar value of your sick leave by your actuarial life expectancy in months. The result is a lifetime monthly credit which reduces your cost for health insurance for as long as you remain enrolled in any NYSHIP option. The amount of your monthly credit will remain the same throughout your lifetime. However, the balance you pay may change each year. (See *"Estimate the value of your sick leave credit,"* on page 19.)

At the time you retire, if you are eligible to use sick leave credits, your agency will report your hourly rate of pay and accumulated sick leave days to the Employee Benefits Division. Six to eight weeks after you receive your last payroll check, you will receive a letter verifying your monthly sick leave credit and the current cost of your retiree health insurance coverage. **Keep this letter for future reference.** If you do not receive this information within eight weeks after your last payroll check, write to the Employee Benefits Division or call (518) 457-5754 (Albany area) or 1-800-833-4344.

You can use a maximum of 200 working days of earned sick leave to calculate your sick leave credit.

If the credit from your unused sick leave does not fully cover your share of the monthly premiums, you must pay the balance. If the credit exceeds your share of the monthly premiums, you will not receive the difference.

> Premium rates are recalculated each year. If the retiree premium rises, the balance you must pay will also rise. New rates are announced by mail and posted on our Web site during Option Transfer Period each year. Each year, to calculate the balance you will pay in the new calendar year, subtract your monthly sick leave credit from the new monthly premium.

When you retire, if the total dollar value of your sick leave amounts to $100 or less, it will be calculated in the same manner as dollar values of $100 or more to provide a lifetime monthly amount of no less than $.01 per month. Or, you may choose to have a credit of less than $100 applied to monthly premiums until the amount runs out. Then, you will contribute the usual enrollee share. Before you retire, you must notify the Employee Benefits Division if you want to use this runout sick leave method.

If you retire while covered under Preferred List provisions, and you retire within one year of your termination, you will be eligible to have sick leave credits applied to your premium in retirement.

Dual Annuitant Sick Leave Credit

Ask your agency Health Benefits Administrator if you are eligible for the Dual Annuitant Sick Leave Credit. Under this provision, you may specify, at the time of your retirement, that you want your dependent survivors (see *"Coverage for Your Dependent Survivors"* on page 22) to be able to use your monthly sick leave credit toward their NYSHIP premium if you die. This is called the Dual Annuitant Sick Leave Credit. If you choose the Dual Annuitant Sick Leave Credit, you will use 70 percent of your sick leave credit for your premium for as long as you live. Your eligible dependents who outlive you may continue to use 70 percent of the monthly credit for their NYSHIP premium. **If you want this option, you must choose it before your last day on the payroll.**

In the example in *"Estimate the value of your sick leave credit"* on page 19, your monthly sick leave credit is $26.61. If you choose the Dual Annuitant option, your monthly sick leave credit will be 70 percent of $26.61, which is $18.63 in this example.

The monthly sick leave credit (of $18.63 in this example) is available to your dependents as long as they remain eligible for NYSHIP and are enrolled as dependent

survivors. The monthly premium for your dependents' continuation in NYSHIP will be reduced by your monthly sick leave credit ($18.63 in this example). This credit cannot be applied to a COBRA premium and cannot be combined with your spouse's (or domestic partner's) sick leave credit, if any.

To elect the Dual Annuitant Sick Leave option, if offered by your employer, contact your agency Health Benefits Administrator before you retire. You may choose the Dual Annuitant option whether you have Individual or Family coverage at the time you retire. **If you do not indicate a choice before your retirement becomes effective, all of your leave credit (up to a maximum of 200 days) will be applied to your premium automatically and your dependent survivors will not have any sick leave credit to offset the cost of the NYSHIP premium.**

This opportunity to elect Dual Annuitant Sick Leave is available only once, at the time you retire. Once you elect Dual Annuitant Sick Leave, you may not discontinue it. If your dependents die before you, you will retain the 70 percent sick leave credit. If you remarry, your 70 percent sick leave credit will be available to your covered dependent survivors.

Married couples who are both eligible for NYSHIP

If you and your spouse (or domestic partner) have chosen a single Family coverage, each of you keeps the right to apply sick leave credits toward your health insurance premium in retirement. Your dependent spouse may choose to re-enroll independently in NYSHIP at any time. Upon re-enrolling, a monthly sick leave credit will be established for your retired spouse, provided the value of his or her unused sick leave can be documented.

Therefore, at retirement, your spouse must ask his or her agency to complete PS-410 "State Service Sick Leave Credit Preservation" form. This form provides evidence of your spouse's State service and sick leave credit if he or she wants to obtain New York State Health Insurance Program coverage in the future. Or, at retirement, your spouse may request a letter from his or her agency which verifies total sick leave accruals and indicates salary and negotiating unit. Your spouse must request this form or letter. It is provided only on request when the employee is covered as a dependent.

When your spouse applies for coverage in his or her own name, your spouse should send this completed form PS-410 or agency verification with a letter requesting coverage to the Employee Benefits Division. A spouse who is entitled to the Dual Annuitant Sick Leave Credit may elect it at the time enrollment is reactivated. For information on reactivating enrollment in NYSHIP, your spouse should contact the Employee Benefits Division.

When credit ends

Your monthly sick leave credit ends when you die and may not be used by your surviving dependents, unless you chose the Dual Annuitant Sick Leave Credit. See *"Coverage for Your Dependent Survivors"* on page 22.

Eligible spouse may reactivate own NYSHIP enrollment

Whether or not you choose the Dual Annuitant Sick Leave Credit, if your spouse is a former employee of a New York State agency or Participating Employer and meets the eligibility requirements for continuing health insurance coverage in retirement, your spouse keeps the right to reactivate his or her own NYSHIP enrollment at any time. For example, if you predecease your spouse, your spouse may either continue in NYSHIP as a dependent survivor, or reactivate enrollment in his or her own right.

To establish the sick leave credit, **your spouse must document the value of his or her unused sick leave.** Therefore, at retirement your spouse should request a letter from his or her agency which verifies total accumulated sick leave accruals and indicates negotiating unit and salary. For information on reactivating enrollment in NYSHIP, your spouse should contact the Employee Benefits Division.

Estimate the value of your sick leave credit below or on our Web site, http://www.cs.state.ny.us

This worksheet is for estimating your sick leave credit only. The worksheet is for full-time and part-time employees. If you are paid on an hourly basis, use your hourly salary as the Hourly Rate of Pay.

Work Sheet

Calculate your Hourly Rate of Pay (HRP)

Step 1. Determine "hours worked in a day": Divide the number of hours in a workweek by 5. For example, a 40-hour week divided by 5 equals an 8-hour day, even if you work 4 days of 10 hours each.

Hours worked in a week ÷ 5 =
Hours worked in a day:_____.

Step 2. Determine HRP: Divide your total annual salary at the time of retirement (basic annual salary plus additional constant salary factors such as location pay, shift or geographic differential, inconvenience pay) by one of the following predetermined numbers: 2088 for jobs that are 8 hours a day, 1957 for jobs that are 7 1/2 hours a day, and 1827 for jobs that are 7 hours a day. (Please contact your agency Health Benefits Administrator for calculations other than the three stated above.)

Annual Salary ÷ Predetermined Number =
Hourly Rate of Pay (HRP):_____.

Calculate your Sick Leave Credit

Step 3. Determine the total dollar value of your sick leave: Multiply your hourly rate of pay by the number of sick leave hours you have accumulated up to a maximum of 200 days.

HRP x Hours Unused Sick Leave =
Total Dollar Value of Sick Leave:_____.

Step 4. Determine your monthly credit: Divide the total dollar value of your sick leave by your life expectancy from the table below:

Total dollar value ÷ Life Expectancy =
Monthly Credit:_____.

Example

You want to retire at age 62 (three months from now). Your gross annual salary is $30,000 and you have 400 hours of unused sick leave.

Step 1. Hours Worked in a day:

8 (hours worked in a day)
5) 40 (hours worked in a week)

Step 2. Hourly Rate of Pay (HRP):

$ 14.37 (HRP)
2088) 30,000 (Annual Salary)

Step 3. Total dollar value of your sick leave:

$ 14.37 (HRP) x (hours unused sick leave) =
$5,748 (Total Dollar Value)

Step 4. Your Monthly Credit:

$ 26.61 (Monthly Credit)
Life expectancy - 216) $5,748 (Total Dollar Value)
(from table below)

(To use the electronic calculator on our Web site, http://www.cs.state.ny.us, click on "Employee Benefits." Choose your group under New York State Actives. Choose "Continuing Coverage When You Retire" and click on "Estimate the Value of Your Sick Leave Credit." Click on "Sick Leave Electronic Calculator.")

Actuarial Table*

AGE AT RETIREMENT	LIFE EXPECTANCY	AGE AT RETIREMENT	LIFE EXPECTANCY
50	308 months	59	240 months
51	301 months	60	232 months
52	293 months	61	224 months
53	286 months	62	216 months
54	279 months	63	208 months
55	271 months	64	200 months
56	264 months	65	192 months
57	256 months	66	184 months
58	248 months	67	176 months
		Etc.	

*This table is for employees in the Employees' Retirement System and Teachers' Retirement System and is for regular retirement only. A different actuarial table applies to disability retirements. If you need actuarial rates for different retirement ages, ask your agency Health Benefits Administrator.

Using the example above, you would have $26.61 of sick leave credit each month to help pay the cost of your health insurance as long as you live. If, for example, your share of the monthly cost of health insurance is $100, your total monthly cost would be $100 minus your sick leave credit of $26.61, or $73.39. The amount of $73.39 would be deducted from your pension or billed to you directly each month. **Keep in mind, as the premium increases or decreases, the amount you must pay will also increase or decrease.** Your monthly credit of $26.61 will not change.

This chart shows the use of single annuitant sick leave credit. If you choose Dual Annuitant Sick Leave Credit at the time of your retirement, 70 percent of the monthly credit ($18.63 in this example) is available to you and your surviving dependent to apply toward the health insurance premium.

Deferred Health Insurance Coverage

Ask your agency Health Benefits Administrator if your Participating Employer offers deferred health insurance coverage. Under this provision, you may defer (delay the start of) or suspend your health insurance coverage and the use of your sick leave credits, if any, for a period of time determined by your agency.

There may be advantages to deferring coverage. During the period of deferment, you do not have to pay the NYSHIP premium. Also, when you start your retiree coverage, the monthly credit for your sick leave will be higher than it would have been at the time you retired because it will be calculated when you are older. This will reduce the amount of the health insurance premium you will pay. You may start your retiree health insurance coverage at any time without a waiting period.

If you die while you are in deferred coverage status and had Family coverage at the time you retired and deferred your coverage, your eligible dependents may re-enroll in NYSHIP. They must write to the Employee Benefits Division requesting re-enrollment in NYSHIP **within 90 days** of the date of your death. Eligibility requirements for your dependents to re-enroll in NYSHIP are the same as if you had continued your coverage into retirement.

If you choose Dual Annuitant Sick Leave Credit at the time of retirement and die while in deferred status, your eligible survivors will retain the 70 percent sick leave credit. The amount will be calculated based on your age at the time of death.

If you want this option, you must choose it before your last day on the payroll.

Contact your agency Health Benefits Administrator if you have questions about deferring your coverage.

If you return to work

If you return to State service in a benefits-eligible position with a government agency that participates in NYSHIP, ask your agency Health Benefits Administrator about how your return to work affects your sick leave credit and your status as a retired enrollee in NYSHIP. If you or a dependent is eligible for Medicare, it is important for you to understand how your re-employment will affect NYSHIP coordination with Medicare. Talk to your agency Health Benefits Administrator and be sure your record is updated to show your new status so that your benefits will be correct.

SUMMARY

BEFORE YOU RETIRE:

- **Check the requirements for continuing your health insurance in retirement:**
  - Ask your Participating Employer if your class (group) of employees is eligible to continue health insurance in retirement. If yes, be especially sure to discuss the minimum service requirements.
  - Carefully read the retirement information in this book.
- **If you are eligible to continue your health insurance benefits, ask your agency Health Benefits Administrator to:**
  - Make sure the information on your enrollment record is up to date for you and your dependents: dates of birth, correct spelling of names, effective dates, addresses, etc.
  - Explain the retiree benefit package.
  - Provide information about Dual Annuitant Sick Leave Credit (through which your sick leave credit can be applied toward your surviving dependent's premium) if you accrue sick leave.
  - Provide information about Deferred Health Insurance Coverage if you are eligible for this benefit.
- **If your agency continues NYSHIP coverage after you become eligible for Medicare at age 65, plan ahead to enroll. Contact your Social Security Administration office three months before you or a dependent turns 65 to enroll in Medicare Parts A and B. As a retiree, you must have Medicare Parts A and B *in effect* on the first day of the month in which you reach 65.**

  Although Medicare allows you to enroll up to three months after your 65th birthday, NYSHIP requires you to have Medicare Parts A and B in effect on the first day of the month in which you reach 65. **If you do not apply three months before your birthday, you will have a waiting period before Medicare becomes effective. During that waiting period, you will have a gap in your coverage that could be very costly for you.**

  If you or a dependent is already 65 or over, you must have Medicare Parts A and B *in effect* as your primary coverage the first day of the month after the end of the month in which your employer group coverage ends. Ask your agency Health Benefits Administrator when your employer group coverage ends. Note: Medicare becomes primary for your domestic partner the first of the month in which the domestic partner reaches age 65, regardless of your employment status. Also, regardless of age, Medicare provides primary coverage when you retire if you or your dependent is disabled or develops end stage renal disease.

  Also see *"Medicare"* pages 26-29. Ask your agency Health Benefits Administrator about Medicare premium reimbursement.
- **Moving when you retire?**

  Before you retire:
  - Notify your agency Health Benefits Administrator of any address change.
  - Check with your agency to see if you need to change your health insurance option.

  After you retire:
  - Write to the Department of Civil Service Employee Benefits Division to report any address change.
- **If you do not meet the requirements to continue coverage as a retiree, COBRA or a direct-pay policy will allow you to continue health insurance benefits. Read the chapters on COBRA Continuation of Coverage and Changing from NYSHIP to a Direct-Pay Conversion Contract or ask your agency Health Benefits Administrator for details.**

Continuing Coverage as a Vestee

Health insurance as a vestee

If your employment with a Participating Employer ends before you reach retirement age and you vest (secure rights to) your retirement allowance, you may continue your health insurance coverage while you are in vested status provided:

- you have vested as a member of a retirement system administered by the State or one of its political subdivisions, such as a municipality;

and

- you have met the minimum service requirement, but not the age requirement for continuing health insurance in retirement, at the time employment is terminated. (See *"Eligibility for retiree coverage"* on page 15.)

To continue coverage as a vestee, before your last day of work be sure to contact your agency Health Benefits Administrator to arrange for continuation.

What you pay

If you choose to continue your coverage while in vested status, you are responsible for paying both the employer and employee shares of the health insurance premium. You will be billed monthly.

No sick leave credit

In no case may sick leave credits be applied toward health insurance premium costs either while you are in vested status or after retiring from vested status. (Sick leave credits can be applied toward your premium only if you retire directly from active employment or from Preferred List coverage, not if you leave employment in vested status and retire later.)

Coverage ends permanently if you do not continue as a vestee

If you are eligible to continue coverage during vested status, but you do not do so, or if you fail to make the required premium payments as a vestee, coverage for you and your dependents will be terminated permanently. You may not re-enroll as a vestee at a later date and you lose eligibility for coverage as a retiree.

Note: If your spouse is eligible for NYSHIP coverage in his or her own right, you may be able to continue coverage as your spouse's dependent. This is a less-expensive alternative to full-share vested coverage.

If you are a vestee and you have NYSHIP coverage as a dependent through your spouse, you may re-establish coverage as an enrollee in your own name at any time as long as you have not allowed your coverage to lapse. Ask your spouse's agency Health Benefits Administrator for information. Also contact the Employee Benefits Division to begin coverage in your own name. Act promptly if a pending divorce or other change means you will be losing coverage through your spouse.

Coverage for Your Dependent Survivors

The New York State Health Insurance Program provides an extended benefits period for your survivors if you die.

Extended benefits period at no cost

If you die while you are actively employed by a Participating Employer, your enrolled dependents will continue to receive coverage without charge for two months beyond the last month for which your last health insurance deduction was taken.

If you die while you are retired, your enrolled dependents will have health insurance coverage for three months beyond the month in which you die. The last two months of coverage will be provided at no cost to your dependent survivors.

If you die while you are in vested status, your enrolled dependents will have health insurance coverage for three months beyond the month in which you die. The last two months of coverage will be provided at no cost to your dependent survivors.

If you die while you are enrolled in NYSHIP through COBRA, your enrolled dependents will be eligible for COBRA continuation coverage or conversion to a direct-pay contract.

Who to call

Survivors should contact the employee's agency Health Benefits Administrator (see *"Directory,"* page 136). The Employee Benefits Division sends information about eligibility, enrollment and payment methods to survivors during the extended benefits period.

Coverage after the extended benefits period ends

Your **unremarried spouse,** or domestic partner who has not acquired another domestic partner, and eligible dependent children may be allowed to continue their coverage under NYSHIP after the extended benefits period ends. Ask your agency Health Benefits Administrator whether your agency provides dependent survivor coverage. **If your dependents are eligible for dependent survivor coverage but choose not to participate or fail to make the required payments, coverage will end permanently. They may not re-enroll.**

Whether they are eligible for dependent survivor coverage and what their premium will cost depend on the following circumstances:

If you die as a result of a work-related illness or injury, regardless of your age at the time of death or your length of service, your employer will pay 100 percent of the cost of NYSHIP coverage for your dependents as long as they remain eligible.

If your death is not the result of a work-related illness or injury:

If at the time of your death you were an active employee who had 10 years of service with New York State or an agency eligible to participate in NYSHIP and were 10 years or less from retirement in a retirement system administered by New York State or any of its political subdivisions, your dependents will make the same contribution that active employees make toward the cost of the Empire Plan or HMO premium. The rate is different for dependent survivors of Thruway Authority employees and employees of some other Participating Employers. Contact your agency Health Benefits Administrator for information.

If at the time of your death you were an active employee who had 10 years of service but were not within 10 years of retirement, your dependents would be required to pay both the employer's and the employee's share of the premium. The rate is different for dependent survivors of Thruway Authority employees and employees of some other Participating Employers. Contact your agency Health Benefits Administrator for information.

It may also be helpful to know that if at the time of your death, you were a retiree who retired on or after April 1, 1979, with 10 or more years of active service with the State or with a combination of service with the State, or a Participating Employer or Participating Agency or any political subdivision, such as a municipality, which has been eligible to participate in NYSHIP, your dependents will make the same contribution as active employees make toward the cost of the Empire Plan or HMO premium. The rate is different for dependent survivors of Thruway Authority employees and employees of some other Participating Employers. Contact your agency Health Benefits Administrator for information.

Note: If at the time of your retirement your employer offered and you had chosen the Dual Annuitant Sick Leave Credit, that credit would continue to be used to reduce the enrollee share of the premium for dependent survivors.

If at the time of your death you were a vestee, your dependents may continue coverage by paying the full cost of the Empire Plan or HMO premium.

Cards and benefits

During the extended benefits period, your survivors should continue to use the card(s) they already have under your identification number.

After the extended benefits period ends, if your dependent then enrolls for dependent survivor coverage, the Employee Benefits Division will change the file to the survivor's own name and identification number, and issue a new card. Benefits will change to retiree benefits.

Coverage for your eligible dependents if your spouse loses eligibility or dies

If your surviving spouse or domestic partner loses eligibility or dies, your eligible dependent children may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents (see *"Your dependents"* on page 4). If they no longer meet these requirements, they may enroll in COBRA or convert to a direct-pay contract.

Option changes for dependents

Survivors are covered by the same rules as active employees for changing options. (See *"Annual Option Transfer Period,"* page 2.)

If your family is not eligible for dependent survivor coverage

If your spouse or domestic partner and children are not eligible for survivor coverage under the New York State Health Insurance Program, they may be eligible to continue their coverage in NYSHIP under COBRA or convert to a direct-pay conversion contract as described in the two following sections.

COBRA: Continuation of Coverage

If you lose eligibility for health insurance coverage as an employee of a Participating Employer or as the dependent of an employee or former employee, you may be entitled to continue your health insurance coverage for a limited period under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Ask your agency Health Benefits Administrator whether COBRA applies to your agency and whether you are eligible to continue coverage under COBRA. Ask for details on coverage and the 60-day application deadline. COBRA enrollees must pay the full cost of coverage plus a two percent administrative charge.

Changing From NYSHIP to a Direct-Pay Conversion Contract

Under certain conditions, NYSHIP enrollees and their covered dependents are entitled to direct-pay conversion contracts after NYSHIP coverage ends or after continuation coverage in NYSHIP under COBRA is exhausted. Refer to your Empire Blue Cross and Blue Shield and United HealthCare Certificates for details.

The benefit package and the premium costs for direct-pay conversion contracts differ from what you have had under NYSHIP.

If you or your dependents meet the requirements defined below, you do not need to provide evidence of insurability.

Who is eligible?

You will be given the opportunity to convert to direct-pay conversion contracts with the carriers of your former coverage if you and your covered dependents lose eligibility to continue coverage under NYSHIP for any of the following reasons:

- Termination of employment;
- Resignation;
- Loss of status as an eligible employee or dependent;
- Death of the employee, vestee, or retiree (when the dependent is not eligible for survivor coverage); or
- COBRA continuation period ends.

Employees whose employment is terminated because their positions are abolished may be eligible for continuation of coverage under NYSHIP for up to one year following termination of employment. (See *"Abolition of position and Preferred List"* on page 14.) At the end of this period, these employees may also be eligible to continue coverage for up to 18 months under COBRA and then to change to direct-pay conversion contracts.

Who is *not* eligible?

Direct-pay conversion contracts are **not** available to:

1. Enrollees who voluntarily cancel their coverage;

2. Enrollees who fail to remit required payments during periods of temporary removal from the payroll or enrollees who fail to remit the required cost for coverage continuation under COBRA; or
3. Vestees who have failed to remit payments.

Empire Blue Cross and Blue Shield conversion

Conversion policies are available from Empire Blue Cross and Blue Shield. However, there are limits if you are eligible for Medicare.

If you leave employment and are eligible for Medicare, you may convert your Empire Blue Cross and Blue Shield coverage to a Medicare supplemental contract if you live in New York State. If you live outside New York State, Empire Blue Cross and Blue Shield cannot offer you conversion to a direct-pay contract. Therefore, if you are eligible for Medicare and are planning to leave your job and reside in another state, and you are not eligible to continue the Empire Plan in retirement, you should immediately contact the local Blue Cross and Blue Shield office or other local insurance company in that state to apply for direct-payment coverage.

United HealthCare conversion

A direct-pay conversion policy for medical/surgical coverage is available from United HealthCare. However, there is no conversion right under United HealthCare for Empire Plan enrollees who have existing coverage which would duplicate the conversion coverage.

There is no conversion right for enrollees who are eligible for Medicare because of age.

If you are under age 65 and eligible for Medicare because of disability, you are eligible for conversion to a United HealthCare direct-pay policy unless you have coverage which would duplicate conversion coverage.

Prescription drug coverage

Prescription drug coverage is provided under certain Empire Blue Cross and Blue Shield conversion policies.

Changing to direct-pay conversion contracts

Within 15 days after your coverage ends, you should receive a written notice of any available conversion rights from both Empire Blue Cross and Blue Shield and United HealthCare if:

- You are an Empire Plan enrollee or a surviving dependent of an Empire Plan enrollee and your coverage is terminated for a reason which entitles you to direct-pay conversion coverage;

or

- You elected to continue your coverage under the provisions of COBRA and that continuation period has ended.

Deadline for applying

If you receive this notice within 15 days after your coverage ends, **you must apply within 45 days for direct-pay conversion coverage.**

If you receive this notice more than 15 days but less than 90 days after the day your coverage ends, you will have 45 days from the date you receive the notice to apply for direct-pay conversion coverage.

> If you do not receive notice of your conversion rights, contact Empire Blue Cross and Blue Shield and United HealthCare. **You will have 90 days from the date your coverage ends to apply for conversion coverage.**

No notice for certain dependents

*Written notice of conversion privileges will not be sent to dependents who lose their status as eligible dependents. These are dependents such as a spouse who becomes divorced from the enrollee or whose marriage is annulled, children who reach age 19 and are not full-time students, or full-time students who reach age 25 (or older, if given credit for military service). These dependents must apply directly to the Empire Plan carriers for direct-pay conversion contracts within **45 days** from the date coverage terminated.*

How to request direct-pay conversion contracts

Empire Blue Cross and Blue Shield: To request a conversion policy, call or write to:

Empire Blue Cross and Blue Shield
P.O. Box 1407
Church Street Station
New York, New York 10008-1407
518-367-0025; 1-800-261-5962

Or, if you live outside New York State and are eligible for Medicare, contact the local Blue Cross and Blue Shield office or other local insurance company in your state to apply for a direct-pay contract to supplement Medicare.

United HealthCare: To request a conversion policy for medical/surgical coverage, write to:

United HealthCare
P.O. Box 1600
Kingston, New York 12402-1600

Medicare: When You Must Enroll and Coordinating with NYSHIP

This section explains when NYSHIP requires you to enroll in Medicare. NYSHIP requirements are not the same as Social Security or Medicare requirements. Do not depend on Social Security, Medicare or another employer for information on NYSHIP requirements. If you have questions about NYSHIP requirements for enrolling in Medicare, contact your agency Health Benefits Administrator.

Medicare: A federal program

Medicare is a federal health insurance program for people who are age 65 or older, or have been entitled to Social Security disability benefits for 24 months, or have end stage renal disease (permanent kidney failure). Medicare is directed by the federal Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration). Local Social Security Administration offices take applications for Medicare and provide information about the program.

"Original" (fee-for-service) Medicare has two parts: **Part A, hospital insurance** which can help pay for inpatient hospital care, care in a skilled nursing facility, home health care and hospice care; and **Part B, medical insurance** which can help pay for medically necessary doctors' services, outpatient hospital services, home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

Primary Coverage

A health insurance plan provides "primary coverage" when it is responsible for paying health benefits before any other group health insurance is liable for payment. Be sure you understand which plan provides your primary coverage.

NYSHIP is primary for most active employees

NYSHIP (Empire Plan or HMO) provides primary coverage for you, your enrolled spouse and other covered dependents while you are an active employee, regardless of age or disability. There are exceptions: Medicare is primary for your domestic partner at 65, and provides primary coverage for an active employee or the dependent of an active employee when Medicare eligibility is due to end stage renal disease, as explained on the next page. Also see page 28, *"When an 'active employee' is enrolled as a retiree's dependent."*

If you or your spouse or other dependent turns 65 or becomes disabled while you are an active employee, you may delay enrollment in Medicare Parts A and B until you retire, without penalty. Or, you may enroll as soon as you are eligible and delay activating your benefits until you retire. Or, you may enroll in Part A only, to be eligible for some secondary (supplemental) benefits from Medicare for hospital-related services. There is usually no premium for Medicare Part A.

As an active employee, eligible for Medicare because of age or disability, you can choose Medicare as your primary group insurer only by canceling your enrollment in NYSHIP. *If you do so, there will be no further coverage for you and your dependents under NYSHIP.*

Your benefits will be drastically reduced with only Medicare coverage. While you are an active employee, your spouse or other dependent who becomes eligible for Medicare because of age or disability also may choose Medicare as primary insurer only by canceling enrollment in NYSHIP. *However, their benefits would be drastically reduced because no benefits would be available through NYSHIP.*

Exceptions: Medicare becomes primary for domestic partners at age 65 and for end stage renal disease

Domestic Partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare-eligible at age 65. The domestic partner must have Medicare Part A and Part B in effect when first eligible at 65. However, if the domestic partner becomes Medicare-eligible because of disability, NYSHIP remains primary.

An active employee, or the dependent of an active employee, who develops **end stage renal disease** becomes eligible for primary Medicare coverage and **must** enroll in Medicare Parts A and B under the following circumstances:

Medicare imposes a three-month waiting period after a patient is diagnosed with end stage renal disease before Medicare becomes effective. However, Medicare waives this waiting period if the patient enrolls in a self-dialysis training program within the first three months of the diagnosis or receives a kidney transplant within the first three months of being hospitalized for the transplant.

If there is a waiting period at the onset of end stage renal disease before Medicare becomes effective, NYSHIP continues to be the primary insurer for the three-month waiting period.

Medicare end stage renal disease coordination

After the three-month waiting period, Medicare begins to count a 30-month waiting period that the patient must satisfy before Medicare is primary. The three-month waiting period, if not waived, plus the 30-month waiting period, makes a total waiting period of 33 months.

During the waiting period, NYSHIP (or another employer's plan) continues to be the patient's primary insurer. At the end of the waiting period, Medicare becomes the patient's primary insurer and NYSHIP will be the patient's secondary coverage.

Since Medicare will provide only secondary benefits during the waiting period, NYSHIP does not require Medicare enrollment during this time and will not provide reimbursement for the Part B premium. At the end of the waiting period, when Medicare becomes the primary insurer, NYSHIP requires the patient to have Medicare in effect.

Notify your agency Health Benefits Administrator if you or your dependent is eligible for Medicare because of end stage renal disease. Once Medicare is primary, the State or your employer will reimburse you for the Medicare Part B premium, unless you or your dependent receives reimbursement from another source. Notify your agency Health Benefits Administrator if Medicare coverage for end stage renal disease ends; NYSHIP will again provide primary coverage for an active employee or the dependent of an active employee.

You and your dependents must have Medicare in effect when first eligible for Medicare coverage that is primary to NYSHIP

As soon as you or your covered dependent becomes eligible for Medicare coverage that pays primary to NYSHIP (because of end stage renal disease or domestic partner status), you or your covered dependent must be enrolled in Medicare Parts A and B. You must have it in effect and be entitled to receive Medicare benefits when first eligible even if you also have coverage through another employer's group plan. If you or a dependent is eligible for Medicare coverage that is primary to NYSHIP, but has failed to enroll when first eligible, you will be responsible for the full cost of medical services that Medicare would have covered.

The Empire Plan will not provide any benefits for services that Medicare would have paid for if you or your dependent had enrolled as required by NYSHIP.

When an "active employee" is enrolled as a retiree's dependent

If an active employee of the State or a Participating Employer, age 65 or over, is enrolled in NYSHIP as the dependent of a retired spouse (rather than in his or her own right as an employee), the employee has "retiree" coverage in NYSHIP and must enroll in Medicare when first eligible. Medicare will pay primary to NYSHIP, and the retired spouse will be eligible to receive reimbursement for the Medicare Part B premium on behalf of the active employee, unless reimbursement is received from another source.

When you are no longer an "active employee"

When you are no longer an active employee of the State or a Participating Employer, NYSHIP or Medicare will be primary as follows:

Retirees, vestees, dependent survivors, Preferred List enrollees and their dependents under age 65: NYSHIP continues to provide your primary coverage until you turn 65 or until you become eligible for Medicare due to disability: then Medicare becomes primary. If you develop end stage renal disease, NYSHIP will provide your primary coverage for the three-month waiting period plus the 30-month period described above; then Medicare becomes primary.

If you have Family coverage, NYSHIP will provide primary coverage for your covered dependents until they become eligible for primary Medicare coverage due to age, disability or end stage renal disease. If your spouse or other dependents are covered under other group health insurance, ask the Empire Plan carriers about primary coverage.

Retirees, vestees, dependent survivors, Preferred List enrollees and their dependents age 65 or over: If your employer continues NYSHIP coverage after age 65, Medicare provides coverage that pays primary to NYSHIP. If your spouse is also age 65 or over, Medicare provides coverage that is primary to NYSHIP for him or her. Your spouse under age 65 and/or your other enrolled dependents may be eligible for primary Medicare coverage because of disability or end stage renal disease. You and your dependents must have Medicare Parts A and B in effect when first eligible.

If you are also covered by another employer's group plan

If you are no longer an active employee of the State or a Participating Employer and you have coverage under another employer's group plan, the order of claims payment is 1) current employer plan; 2) Medicare; and 3) NYSHIP.

When to enroll in Medicare

As an active employee, contact Medicare immediately if you, your spouse or enrolled dependent is eligible for primary Medicare coverage due to end stage renal disease. Also, the domestic partner of an active employee must have Medicare Part A and Part B in effect by the first of the month in which the domestic partner reaches age 65.

If you are planning to retire or otherwise leave service, and you or your spouse is 65 or older, contact your Social Security office **three months before active employment ends** to arrange for Medicare Parts A and B. If you are 65 or over when you retire or otherwise leave service with your employer, NYSHIP will no longer be your primary insurer beginning the first day of the month following the month in which your employer group coverage ends. Ask your agency Health Benefits Administrator when your employer group coverage ends. Be sure you have Medicare in effect at that time.

Planning to retire: Avoid a gap in coverage

If you are planning to retire or otherwise leave service with your employer and are under 65, Medicare becomes primary to NYSHIP on the first day of the month in which you reach age 65. Contact Social Security **three months before you reach age 65** to be sure of having Medicare in effect at that time.

Although Medicare allows you to enroll up to three months after your 65th birthday, NYSHIP requires you to have Medicare Parts A and B in effect on the first day of the month in which you reach 65. If you do not apply three months before your birthday, you will have a waiting period before Medicare becomes effective. During that waiting period, you will have a gap in your coverage that could be very costly for you.

Regardless of age, contact your Social Security office if you are planning to retire or otherwise leave service with your employer and you or your spouse or dependent is disabled.

How to enroll

You can sign up for Medicare by telephone and mail. Contact your local Social Security office at 1-800-772-1213. Ask for a Teleclaim appointment. Information about applying for Medicare is also available on the Web at http://www.medicare.gov.

Medicare premium reimbursement

If you or your dependent is Medicare primary, the State or your Participating Employer will reimburse you for the usual (base) cost of "original" Medicare Part B monthly premiums ($50 per month in 2001) unless you are receiving reimbursement from another source. Retirees, vestees, dependent survivors and enrollees covered under Preferred List provisions and COBRA enrollees who become Medicare primary at age 65 are reimbursed automatically. Domestic partners and enrollees who become Medicare primary before age 65 because of disability or end stage renal disease must apply for reimbursement.

Reimbursement for dependents not automatic

If your dependent is eligible for primary Medicare coverage (as described above for domestic partners and end stage renal disease), reimbursement for the dependent's Medicare Part B premium is not automatic. 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.

Loss of eligibility for Medicare premium reimbursement

If you or a dependent loses eligibility for Medicare premium reimbursement (for example, you return to work in a benefits-eligible position for New York State or a Participating Employer, you move out of the country or your spouse dies), you must contact your agency Health Benefits Administrator or the Employee Benefits Division. You will be liable for premiums that are incorrectly reimbursed.

Medicare+Choice (Risk) HMOs and your Empire Plan coverage

As a retiree, be sure you understand that if you or your dependent enrolls in an HMO under a Medicare+Choice (Risk) Contract (in addition to your Empire Plan coverage), the Medicare+Choice (Risk) HMO replaces your traditional Medicare coverage and drastically reduces or eliminates benefits under the Empire Plan. Refer to your Empire Plan Certificates for details on coordinating your Empire Plan coverage with Medicare.

Re-employment

If you return to active employment in a benefits-eligible position with the State or a Participating Employer, for example, from retirement, and meet the health benefits eligibility requirements for active employees, NYSHIP again provides primary coverage for you, your spouse and other enrolled dependents. Medicare is primary, however, for the domestic partner age 65 or over of an active employee, unless the domestic partner is disabled.

When to contact your agency Health Benefits Administrator

At the time of your re-employment, ask your agency Health Benefits Administrator to arrange to notify the Empire Plan carriers or your HMO of your re-employment. Be sure to find out the effective date for your NYSHIP plan to resume providing coverage that is primary to Medicare.

Keeping Your Coverage Up To Date

To keep your coverage up to date, you must notify your agency Health Benefits Administrator if...

Your home address changes

Your phone number changes

Your name changes

Your Family Unit Changes

- You marry or divorce; your domestic partner no longer qualifies
- You want to add a dependent
- You no longer have any eligible dependents
- Your dependent loses eligibility
- You no longer wish to provide coverage for a dependent
- You have a disabled dependent
- Your spouse dies

Your Employment Status Changes

- You are going to retire from service with your Participating Employer
- You are affected by a layoff
- You are going on leave without pay
- You are going on Family and Medical Leave
- You want to continue your health insurance coverage while in vested status
- You have questions about continuing coverage under COBRA
- You are no longer an active employee of your Participating Employer and you become eligible for primary Medicare coverage due to age

You Have Questions About NYSHIP

- You have questions concerning your family's eligibility for health insurance coverage
- You have questions about changing your type of coverage (Family/Individual)
- You have questions about changing your health insurance option; you would like information about NYSHIP HMOs
- You or a covered dependent becomes eligible for Medicare benefits because of end stage renal disease or because your domestic partner will be 65 soon
- You want to know how to coordinate your NYSHIP benefits with Medicare

Other

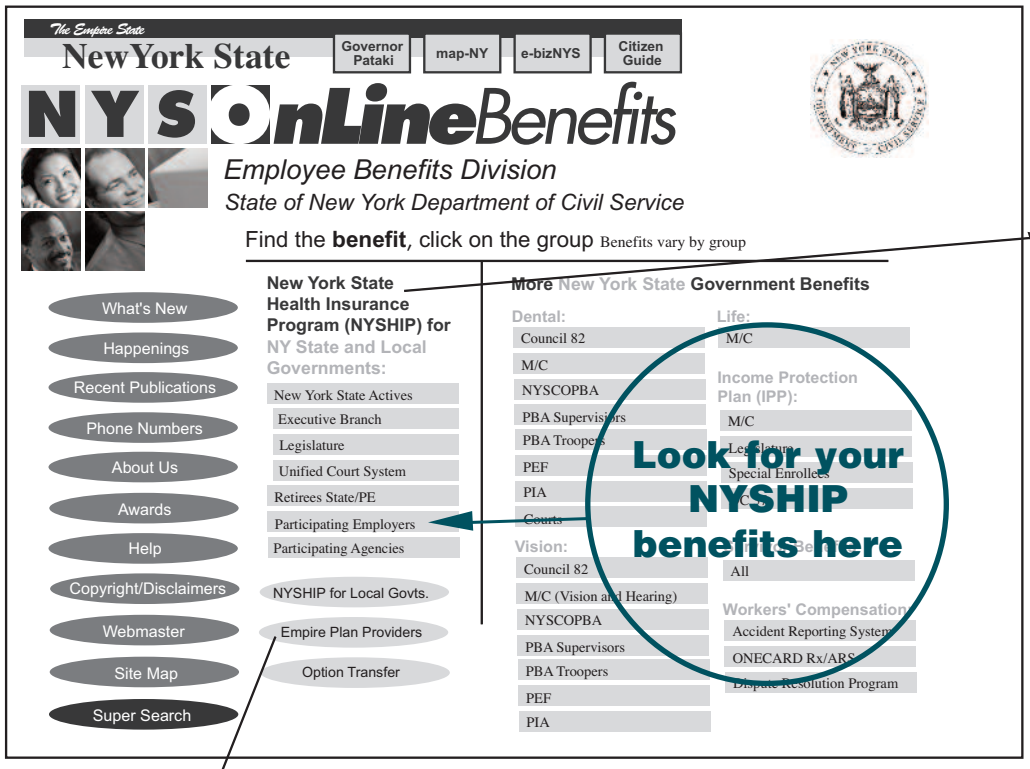
- Your New York Government Employee Benefit Card is lost or damaged
- You become disabled and want to apply for a waiver of premium
- You want to cancel your health insurance coverage to obtain dependent status under your spouse's NYSHIP coverage
- You want to cancel your coverage
  (Notify the Employee Benefits Division in writing if you want to cancel your COBRA coverage.)
- You return to service with the State or your Participating Employer

Please refer to the "Directory of Agency Health Benefits Administrators" on page 136.

Visit us on the Web at http://www.cs.state.ny.us

Check our New York State Department of Civil Service Employee Benefits Division Web site at http://www.cs.state.ny.us. Publications are available on our site, which meets universal accessibility standards adopted by New York State for NYS Agency Web sites. If you don't have access to the Internet, visit your local library. Most libraries have computers linked to the Internet.

Click on Employee Benefits for timely information about your Empire Plan benefits.



Health Insurance
Choose your group to go to *"What's Inside"* for information about NYSHIP and the Empire Plan

Empire Plan Providers
Link directly to the Participating Provider Directory on the United HealthCare Web site

Other Web sites:

Empire Blue Cross and Blue Shield

http://www.empireblue.com

Use your identification number to register to check hospital claim status, complete a Coordination of Benefits form or fill out a dependent student questionnaire.

United HealthCare

http://myuhc.com

Use group number 030500 and your identification number to register and check medical claims.

Express Scripts

http://www.express-scripts.com

To refill a prescription on file with the Express Scripts Mail Service pharmacy, or to check the status of your refill order, choose Mail Service Prescriptions Refill. This site also offers general information on prescription medications.

NEW YORK STATE

THE EMPIRE PLAN

Empire Plan benefits are available for a wide spectrum of services obtained anywhere in the world. The Empire Plan gives you freedom of choice:

- Your choice of acute care hospitals for medical or surgical admissions is almost unlimited.
- You may choose a participating provider or non-participating provider for each covered service you need. Benefits vary, as summarized on the next page.
- For mental health or substance abuse treatment, you will obtain comprehensive coverage when you call ValueOptions and follow their recommendation or a lower level of benefits if you don't.
- For covered, medically necessary home care services and durable medical equipment or supplies, the Empire Plan pays in full when you call the Home Care Advocacy Program (HCAP) and use an approved provider. Lower levels of benefits are available outside HCAP.
- For covered, medically necessary chiropractic treatment and physical therapy, choose a Managed Physical Network (MPN) network provider; receive a lower level of benefits if you don't.
- If you have Empire Plan prescription drug coverage, you may fill prescriptions for covered, medically necessary generic or brand-name drugs at a participating pharmacy, by mail or at a non-participating pharmacy. Benefits vary, as summarized on the next page.

Some of the valuable features of the Empire Plan are summarized on this page and the facing page. The Empire Plan Certificates are the controlling documents.

You may use the following summaries as a guide for filing claims.

Benefits Management Program

1-800-992-1213

To protect your benefits, **you must call** the Empire Plan Benefits Management Program, administered by Intracorp, for:

- Pre-Admission Certification, before a maternity or scheduled hospital admission or within 48 hours after an emergency or urgent hospital admission; before admission or transfer to a Skilled Nursing Facility
- Prospective Procedure Review before you have magnetic resonance imaging (MRI), unless you are having the test as an inpatient in a hospital.

The Benefits Management Program also provides:

- A paid-in-full voluntary Specialist Consultant Evaluation when arranged through the Benefits Management Program
- Voluntary Medical Case Management to help coordinate services for serious conditions and High Risk Pregnancy Program.

Empire Blue Cross and Blue Shield

518-367-0009
(Albany area and Alaska),
1-800-342-9815 (NYS and other states except Alaska)

The following is a brief list of the benefits available under the hospitalization portion of the Empire Plan, subject to limitations and exclusions described in the Empire Plan Certificate.

- Inpatient hospital care for medical, surgical and maternity conditions, including anesthesia administered by a hospital employee
- Skilled nursing facility care in lieu of hospitalization
- Hospice care
- Outpatient hospital care for:
  - Pre-admission testing/ pre-surgical testing prior to admission
  - ** Emergency care
  - * Surgery
  - * Diagnostic radiology and diagnostic laboratory tests
  - * Mammography screening
  - * Administration of Desferal for Cooley's anemia
- Dialysis treatment
- Chemotherapy; Radiation therapy
- Physical therapy ($10 copayment)
- Transplants Program

Blue Cross member hospitals will bill Empire Blue Cross and Blue Shield directly but will require you to pay any copayment due for outpatient services. When non-member hospitals ask you for full payment, send the bill to Empire Blue Cross and Blue Shield for reimbursement.

* Services marked by an * may be subject to a $25 copayment.
** Emergency Room Services may be subject to a $35 copayment.

United HealthCare

1-800-942-4640

United HealthCare provides coverage for the following types of services when medically necessary, subject to the limitations and exclusions described in the Empire Plan Certificate:

- *Office visits
- *Surgeon's fees when not covered by Empire Blue Cross and Blue Shield
- *In-hospital anesthesia unless covered by Empire Blue Cross and Blue Shield or administered by your doctor
- Maternity care
- Pediatric care (well-child visits)
- Routine newborn care
- *Specialist consultations
- Durable medical equipment and related supplies • diabetic and ostomy supplies • home nursing • home infusion therapy • certain home health care services when they take the place of hospitalization or care in a skilled nursing facility, such as home health aides, physical, occupational and speech therapy, prescription drugs and laboratory services, are paid in full under the Home Care Advocacy Program (HCAP). You must call HCAP at 1-800-638-9918. You will pay a significantly higher share of the cost if you don't use HCAP.
- *Chiropractic care and physical therapy when you choose a Managed Physical Network, Inc. (MPN) provider. Non-network coverage has substantially lower benefits.
- Infertility benefits, including paid-in-full benefits at Centers of Excellence. You must call 1-800-638-9918 for prior authorization of Qualified Procedures regardless of provider. Authorized Qualified Procedures covered up to lifetime maximum hospital/medical benefit of $25,000.
- *Diagnostic laboratory and radiology services, including mammography
- *Podiatry
- Radiation therapy
- Chemotherapy
- Hemodialysis
- Ambulance service
- Prosthetics
- Hospital charges upon expiration of Empire Blue Cross and Blue Shield benefits
- Cardiovascular Risk Reduction Program
- Empire Plan NurseLine℠ 24-hour health information at 1-800-439-3435

* Services marked by an * may be subject to a $10 copayment.

When Using the Participating Provider Program:

You obtain services from a provider who has an agreement in effect with United HealthCare to provide services under the Empire Plan.

You pay a copayment to the provider as described in the Empire Plan Certificate.

Participating Providers submit your claims directly to United HealthCare.

United HealthCare pays Participating Providers directly for all covered services.

When Using the Basic Medical Program:

You obtain services from a Non-participating Provider.

You submit a claim to United HealthCare.

United HealthCare reimburses you for covered services, up to the reasonable and customary amount, subject to a deductible and coinsurance as described in the Empire Plan Certificate. You have no annual or lifetime dollar maximum on covered benefits under the Basic Medical portion of the Empire Plan.

GHI/ValueOptions

1-800-446-3995

The Empire Plan Managed Mental Health and Substance Abuse Program offers two levels of benefits. **You must call** ValueOptions before you receive services and you must follow ValueOptions' recommendations to receive network coverage, the highest level of benefits: no deductible; no copayment for inpatient treatment; $10 copayment for substance abuse visits; $15 copayment for mental health visits (for crisis intervention, up to 3 visits are paid in full); no limit on medically necessary mental health and substance abuse visits; unlimited inpatient mental health coverage when medically necessary; inpatient substance abuse care limited to three stays per lifetime, with more considered case by case.

If you do not call ValueOptions or do not follow their recommendations, non-network coverage, a more limited benefit, is available for medically necessary care. These benefits are significantly lower than those available when you call and follow recommendations. For example, for non-network care, you pay a $2,000 deductible for inpatient/$500 deductible for outpatient care. The plan pays 50 percent of the network allowance, and you pay the remainder. There are limits on inpatient and outpatient benefits and annual and lifetime dollar maximums if you do not use ValueOptions.

CIGNA/ Express Scripts

1-800-964-1888

If you have prescription drug coverage under the Empire Plan, your coverage provides the following. Refer to your Certificate for details.

Copayments

You pay a $5 copayment for generic drugs and a $15 copayment for brand-name drugs that have no generic equivalent. For brand-name drugs that have generic equivalents, you pay a $15 copayment plus the difference in cost between the brand-name drug and its generic equivalent.

Participating Pharmacy

You may use your New York Government Employee Benefit Card to fill your prescriptions for covered medications at any participating pharmacy.

Medicine Through the Mail

You may fill your prescriptions through the mail by using the Express Scripts Mail Service. A pharmacist is on call 24 hours a day for emergencies.

Non-Participating Pharmacy

If you use a non-participating pharmacy or you do not use your card at a participating pharmacy, you will pay the pharmacy the full cost of the prescription and then submit a claim to Express Scripts for partial reimbursement.

Prior Authorization

You must call for prior authorization for certain drugs.

EMPIRE PLAN
CERTIFICATE OF INSURANCE

Introduction

The Empire Plan is the result of collective bargaining between the State and unions representing its employees. It has been designed to provide you with a complete health insurance benefits package at the lowest possible cost. A number of features have been included in the Empire Plan to manage costs, for both you and your employer, and to ensure that the health care you receive is that which is the most appropriate for you.

This Certificate of Insurance describes the health insurance coverage provided by the Empire Plan. The Plan is administered by the Department of Civil Service and includes the following basic elements of coverage:

- Hospital and related benefits through Empire HealthChoice, Inc., doing business as Empire Blue Cross and Blue Shield (copayments apply for certain services);
- Medical/surgical benefits through United HealthCare for a modest copayment when you choose participating providers;
- Basic Medical coverage through United HealthCare when you choose non-participating providers;
- Mental Health and Substance Abuse Program through GHI/ValueOptions;
- Benefits Management Program through Intracorp for prior authorization of hospital admissions, skilled nursing facility admissions and MRI;
- Home Care Advocacy Program through United HealthCare for home care services, durable medical equipment and certain supplies;
- Managed Physical Medicine Program through United HealthCare/Managed Physical Network Inc.;
- Centers of Excellence for Transplants Program through Empire Blue Cross and Blue Shield;
- Centers of Excellence for Infertility Treatment through United HealthCare; and
- Prescription drug coverage through CIGNA/Express Scripts, unless prescription drug coverage is provided through a union Employee Benefit Fund.

You should familiarize yourself with the Empire Plan by reading this certificate so that you will be able to use effectively the benefits it provides. Pay particular attention to the information about the Empire Plan's Benefits Management Program, the Home Care Advocacy Program, the Managed Physical Medicine Program, Transplants Program, Infertility Benefits, the Mental Health and Substance Abuse Program and prior authorization requirements for certain drugs. Designed to control costs and provide you with the most appropriate care, these features have requirements which must be met to obtain full benefits.

Section I:
THE EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM

Hospital, Skilled Nursing Facility and Medical Benefits Management Program

The Empire Plan Benefits Management Program is administered by Intracorp.

You and your family must follow Benefits Management Program procedures, described below, to protect your Empire Plan benefits. Your share of the cost will be higher if you don't follow these procedures.

Applies when the Empire Plan is primary

The Empire Plan Benefits Management Program requirements apply when the Empire Plan is your primary health insurance coverage. (The Empire Plan is primary when it is responsible for paying for health benefits first, before any other group plan or HMO is liable for payment.) Requirements also apply to a Medicare-primary active employee or dependent before admission to a skilled nursing facility.

These requirements apply if you live or seek treatment anywhere in the United States, including Alaska and Hawaii.

These requirements also apply when you or your enrolled dependents have primary coverage through an HMO with secondary coverage under the Empire Plan, and you choose not to use the HMO.

If you will be admitted to a medical center or hospital operated by the U.S. Department of Veterans' Affairs, and will be using your Empire Plan benefits, you must comply with the requirements of the Empire Plan Benefits Management Program.

You must call the Benefits Management Program at 1-800-992-1213

You must call for pre-admission certification before any elective (scheduled) hospital admission that will include an overnight stay in a hospital.

You must call before the hospital admission. Call as soon as your doctor suggests admission to the hospital. Call at least two weeks in advance of the admission, if possible. If you did not receive at least two weeks' notice from your doctor, contact the Benefits Management Program immediately. The nurse will make every effort to complete the review before your admission.

You must call the Benefits Management Program before the birth of a child. Call as soon as the doctor confirms the pregnancy. You must call again if you are admitted to the hospital during the pregnancy for complications or for anything other than the delivery of the baby.

You must call the Benefits Management Program within 48 hours after an emergency or urgent admission. This includes admission if you were scheduled for outpatient surgery and remained in the hospital overnight due to a complication. See *"Empire Blue Cross and Blue Shield Certificate of Insurance Hospital and Related Expense Coverage" on page 43* for definitions of "emergency," "urgent" and "maternity" admissions.

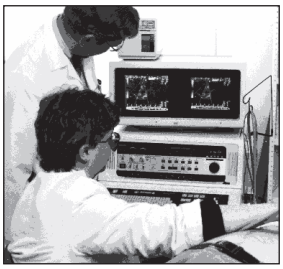
You must call the Benefits Management Program for certification before admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility.

You must call the Benefits Management Program for Prospective Procedure Review before having an elective (non-emergency) Magnetic Resonance Imaging (MRI), unless you are having the test as an inpatient in a hospital. (See *"Prospective Procedure Review: MRI"* on page 38 for details.)

Who calls?

You, a member of your family or household, your doctor or a member of your doctor's staff may place the call. In the case of an emergency or urgent admission, the hospital admitting office may place the call for you.

Where this section refers to "you" making the call, keep in mind that other people may also call. However, you are responsible for seeing that the Empire Plan Benefits Management Program receives the call.



Why Benefits Management?

This program helps protect you and the Empire Plan by avoiding unnecessary service. Empire Plan enrollees need to evaluate the medical appropriateness of services they receive. Every medical procedure includes some risk. It can be unhealthy to be overtreated or undertreated. The costs associated with unnecessary services are shrinking our health benefits dollars. Money spent on unneeded services reduces the pool of money left to cover essential treatment.

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

Read 1 through 6 carefully to see how the Empire Plan Benefits Management Program's benefits and responsibilities apply to you and your family.

1. Pre-Admission Certification for hospital admission

To protect your Empire Plan benefits, you **must call** the Benefits Management Program at 1-800-992-1213 for pre-admission certification. You **must call:**

- before any elective (scheduled) hospital admission;
- before the birth of a child;
- within 48 hours after an emergency or urgent admission.

In addition, you **must call** before admission to a skilled nursing facility, as explained in *"Pre-Admission Certification for skilled nursing facility admission"* on page 37.

After you call the Benefits Management Program for pre-admission certification, your Benefits Management Program nurse will call your doctor's office and speak with your doctor or the doctor's staff. If the information about your medical condition indicates that the hospital setting is medically necessary according to nationally accepted standards, the admission will be pre-certified. Pre-admission certification assures that Empire Plan benefits will be available to you to the full extent for covered services.

If the medical necessity of the admission is not confirmed, one of the Benefits Management Program's board-certified, practicing physician advisors will discuss the hospitalization with your doctor. If necessary, a second physician advisor, from the same or related specialty as your doctor, will also discuss the hospitalization and various alternatives with your doctor.

If the physician advisor does not agree that the admission is medically necessary, your admission will not be certified.

Within 24 hours after the Benefits Management Program completes the review, the program will notify the hospital, you and your doctor whether the admission is certified. Empire Blue Cross and Blue Shield will also be notified.

You pay a higher share of the cost if you do not follow the Empire Plan Benefits Management Program procedures

If you do not follow the pre-admission certification requirements:

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

or

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

or

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

- a $200 hospital deductible

and

- a $100 copayment for each day it is determined that your hospitalization is not medically necessary.

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

- a $200 hospital deductible

and

- a $100 copayment for each day it is determined that your hospitalization is not medically necessary.

Certification does not guarantee coverage

Certification of a hospital admission means that the Empire Plan Benefits Management Program has found the inpatient setting appropriate. This certification does not guarantee coverage. The Empire Plan carriers will determine eligibility and benefits as part of the claims review process. For example, although the inpatient setting may be certified for your spouse's surgery, benefits are not available if you discontinued his or her coverage before the admission. As another example, if the hospital setting was approved for surgery that the carriers later determine to be cosmetic surgery or an experimental or investigative procedure, benefits are not available. The Empire Plan does not cover cosmetic surgery and experimental or investigative procedures or related hospital care. Call Empire Blue Cross and Blue Shield or United HealthCare if you have questions about benefits for hospitalization or a certain procedure.

Pre-Admission Certification for skilled nursing facility admission

You must call the Empire Plan Benefits Management Program at 1-800-992-1213 for pre-certification before admission to a skilled nursing facility, including transfer from a hospital to a skilled nursing facility. By calling prior to admission, you will know whether your care in a skilled nursing facility meets the criteria for Empire Plan benefits. Also, if your stay 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 end.

If the Empire Plan is your primary coverage, skilled nursing facility care is covered under the Empire Plan if:

1. The care in a skilled nursing facility is medically necessary. Care is medically necessary when it must be provided by skilled personnel to assure your safety and achieve the medically desired result; and
2. Inpatient hospital care would have been required if care in a skilled nursing facility were not provided.

If the above conditions are not met, the skilled nursing facility care is not covered under the Empire Plan.

Custodial care, which is primarily assistance with the activities of daily living, is not covered under the Empire Plan.

Pre-admission certification for transplant surgeries

You must call Empire Blue Cross and Blue Shield at 518-367-0009 or 1-800-342-9815 for pre-admission certification of admissions for the following transplant surgeries: bone marrow, peripheral stem cell, cord blood stem cell, heart, heart-lung, kidney, liver, lung and simultaneous kidney-pancreas. This requirement applies whether or not you choose to participate in the Centers of Excellence for Transplants Program.

2. Concurrent Review

Once you or your enrolled dependent is hospitalized, the Empire Plan's Benefits Management Program will continue to monitor your progress through the concurrent review program. The goal of concurrent review is to encourage the appropriate use of inpatient care. If the Benefits Management Program determines that inpatient care is no longer medically necessary, you, your doctor and the facility will be notified in writing no later than the day before the day on which Empire Plan inpatient benefits cease.

Note: The Benefits Management Program only gives advance notice that inpatient benefits will cease because inpatient care is no longer medically necessary. To check when your hospital benefits will cease for other reasons, contact Empire Blue Cross and Blue Shield at 1-800-342-9815.

3. Discharge Planning

If you or your enrolled dependent needs special services after hospitalization, the Benefits Management Program's discharge planning unit nurses can help in consultation with hospital discharge planners. In consultation with your doctor, the Benefits Management Program nurse will help arrange for medically necessary services and coordinate these services for you and your family. These services will be covered in accordance with Empire Plan provisions. For home health care and durable medical equipment/supplies, you must call the Home Care Advocacy Program, as explained in the *"Home Care Advocacy Program"* section on pages 76-80.

4. Prospective Procedure Review: MRI

To protect your Empire Plan benefits, you must call the Benefits Management Program if you or one of your enrolled dependents is scheduled for an elective (non-emergency) Magnetic Resonance Imaging (MRI), unless you are having the test as an inpatient in a hospital.

Call as soon as your doctor suggests an MRI. 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 Benefits Management Program, call your Benefits Management Program nurse **before** you go ahead with the procedure.

Your call will start the review process

A Benefits Management Program representative will call your doctor to discuss his or her recommendation. If the Benefits Management Program determines that the MRI is medically necessary and appropriate, the MRI will be approved and covered in accordance with Empire Plan provisions. Written notice will be mailed to you within 24 hours. If you call at least two weeks ahead, the Empire Plan's Benefits Management Program will also send you a brochure which explains your MRI.

If the Benefits Management Program determines that the MRI is not medically necessary, and you choose to proceed with the MRI, you will be responsible for the full cost of the MRI. You will receive no Empire Plan benefits.

You do not have to call the Benefits Management Program before an emergency MRI. When Empire Blue Cross and Blue Shield or United HealthCare receives the claim for the MRI, Empire Blue Cross and Blue Shield or United HealthCare will determine whether the MRI was performed on an emergency basis and whether the MRI was medically necessary.

An MRI is performed on an emergency basis when it is given within 72 hours after an accident or within 24 hours after the first appearance of the symptoms of the illness when all of the following conditions are met: there is a sudden, unexpected onset of a medical condition; and immediate care is necessary to prevent what could reasonably be expected to result in either placing your life in jeopardy or serious impairment to your bodily functions.

There are penalties for not complying with the Prospective Procedure Review requirements

If you fail to call the Empire Plan Benefits Management Program, Empire Blue Cross and Blue Shield and/or United HealthCare will conduct a medical necessity review. If the review does not confirm that the MRI was medically necessary, you will be responsible for the full charges. No benefits will be paid under your Empire Plan coverage. If you fail to call the Benefits Management Program and the Empire Blue Cross and Blue Shield and/or United HealthCare review confirms that the MRI was medically necessary but not an emergency, you will be responsible for paying the following:

- When the MRI is performed in the outpatient department of a hospital, you are liable for the payment of the lesser of 50 percent of the covered hospital charge or $250. You will also be responsible for the $25 hospital copayment.

- When the provider(s) administering and/or interpreting the MRI is an Empire Plan participating provider, you are liable for the payment of the lesser of 50 percent of the scheduled amounts or $250. You will also be responsible for the $10 copayment.
- When the provider(s) administering and/or interpreting the MRI is not an Empire Plan participating provider, you are liable for the lesser of 50 percent of the reasonable and customary charges 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. (The coinsurance is the 20 percent you pay for covered services by non-participating providers, up to an annual maximum.)

Voluntary Specialist Consultant Evaluation

You may request a voluntary specialist consultant evaluation for any scheduled procedure. The Benefits Management Program will give you a list of up to three physicians whose specialty is similar to your doctor's. After you determine which of these doctors you prefer to see, the Benefits Management Program will arrange for the specialist consultant evaluation. The consultation will be provided at no cost to you.

However, if the specialist from whom you obtained the specialist consultant evaluation performs the procedure, the specialist consultant evaluation will not be considered a covered expense under the Empire Plan; you will be responsible for the cost of the evaluation.

Once the evaluation is completed, it is up to you whether to have the procedure or surgery. But remember, if you decide to go ahead and you will be hospitalized for the procedure, you must call the Empire Plan Benefits Management Program so they can pre-certify the hospital setting.

5. Medical Case Management

Medical case management is a voluntary program to help you identify and coordinate covered services that the patient needs.

Some serious conditions, such as severe burns, head injuries, neonatal (newborn) complications or certain chronic conditions, may require extended care. If you or a member of your family requires this type of care, you may be faced with many decisions about treatment plans and facilities. The Benefits Management Program can provide information that may help you make the choices that are best for you.

Pre-admission certification and concurrent review help the Benefits Management Program determine if medical case management would be appropriate. If the Benefits Management Program decides that this service could help you and your family, a nurse coordinator, who is familiar with benefits available under the Empire Plan and local and regional health care resources, will contact you. The nurse will meet with you and your family to discuss the patient's medical situation.

Your acceptance of this service is voluntary. With your written consent, the nurse and your attending physician will identify treatment options covered under the Empire Plan so that you and your family have the information available to make the best medical decisions possible. The nurse will also identify any community resources which may be available for you or your family.

6. High Risk Pregnancy Program

The Empire Plan Benefits Management Program offers special help for pregnancies. Call as soon as you know you're pregnant. The Benefits Management Program will help identify possible problems and will work with you and your doctor. See below for details.

Healthy Babies

The Empire Plan Benefits Management Program Helps Identify Risks Early

Pregnant? First steps...

Photo: March of Dimes

Every year about 9,000 babies are born to employees and their family members who are covered under the Empire Plan. We want every mother and baby to have the best possible start. That's why the Empire Plan gives mother and baby the coverage they need. And that's why the Empire Plan Benefits Management Program offers special services for pregnancy for enrollees who have the Empire Plan as their primary coverage.

The first steps for a healthy baby are up to you – they're steps you take long before your baby's born:

Step 1 Call your doctor...

Pregnant? Call your doctor! The first three months of pregnancy are when you can do the most for your baby. Start your doctor visits during the first month of pregnancy.

Step 2 Call 1-800-992-1213...

Doctors report problems in three out of every ten pregnancies. But there's good news: **Early diagnosis and care can mean a healthy baby.**

The Benefits Management Program helps identify possible problems and works with mother and doctor throughout the pregnancy. This partnership can make a world of difference!

Call 1-800-992-1213 as soon as you know you are pregnant. Call early – during the first month is best. (If you don't call before your maternity hospital admission, you pay a higher share of the cost.)

Tell the Benefits Management Program you're calling about your pregnancy. The maternity specialist will ask you several easy questions such as, "Is this your first pregnancy/have you had problems during previous pregnancies?" – questions to help determine if you or your baby is at risk.

The questions take five minutes, at the most. And your answers are strictly confidential.

Free book can help you: When you call, the Benefits Management Program will offer to send you a free book on pregnancy.

Follow-up: If the maternity specialist identifies any possible problems, the specialist will ask to keep in telephone contact with you every four to six weeks. Your participation is voluntary.

One of the program's registered nurses who specializes in maternity or newborn care will call you back. During the calls, the nurse will talk with you about your progress and any problems you are experiencing. The nurse also will call your doctor to discuss progress and possible follow-up.

You may ask questions, too. During the calls, the Benefits Management Program nurse will answer general questions. And, if you need help determining what questions to ask your doctor, the nurse will help you think through those questions.

Step 3 Be informed...

Ask a lot of questions: ask your doctor, the nurse, the Benefits Management Program and community resources. There is information available to help you have a healthy baby.

More About the Benefits Management Program

Certification letter

The Benefits Management Program will mail a letter to you within 24 hours after the Empire Plan prospective procedure review and/or pre-admission certification review is completed. If your letter has not arrived, call the Benefits Management Program before your procedure or admission to find out the results of the review.

Call again

You **must call** the Benefits Management Program **again** in certain situations:

- Admission postponed: If you received pre-admission certification for admission to a hospital or skilled nursing facility and there is a change in the scheduled date of your admission, you must call the Benefits Management Program again to change the date.
- Re-admission: If you received pre-admission certification for a hospital or skilled nursing facility admission and you must be re-admitted for the same problem, you must call the Benefits Management Program again.
- MRI postponed: If the Benefits Management Program approved your MRI but you and your doctor decide to postpone the MRI for more than six months, you must call again for another review when the MRI is rescheduled.
- MRI repeated: If you followed prospective procedure review requirements for an MRI and the MRI is scheduled to be repeated, you must call the Benefits Management Program again.

The Benefits Management Program and the Mental Health and Substance Abuse Program

The Benefits Management Program does not replace the Empire Plan Mental Health and Substance Abuse Program, administered by ValueOptions. Call ValueOptions at 1-800-446-3995 before seeking care for mental health and substance abuse problems, including alcoholism.

At times, a person's condition may be so complicated that it is difficult to determine if the required care is medical or mental health/substance abuse related. If you cannot decide, call either ValueOptions or the Benefits Management Program and the person who answers will help you to determine which program applies.

Calling the Empire Plan Benefits Management Program is easy and toll-free

Call 1-800-992-1213 to reach the Benefits Management Program from anywhere in the United States.

Teletypewriter (TTY) for callers using a TTY device because of a hearing or speech disability: 1-800-962-2208.

You may call during business hours - 8:30 am to 5 pm, Monday through Friday. At other times and on holidays, an answering machine will take your information and a representative will return your call. Please leave your name and the best time and place to reach you (with the area code and telephone number) on the following business day. If you don't get a return call in one business day, your message may not have been clear. Please call again.

Be ready to supply the following information to the nurse:

1. Enrollee identification number (from New York Government Employee Benefit Card)
2. Patient's address and phone number (including area code)
3. Doctor's name, address and phone number (including area code)
4. Name of hospital or skilled nursing facility
5. Anticipated date of admission or MRI.

Section II:
EMPIRE HEALTHCHOICE, INC.
doing business as
EMPIRE BLUE CROSS AND BLUE SHIELD
CERTIFICATE OF INSURANCE
HOSPITAL AND RELATED EXPENSES COVERAGE

Introduction

1. **Your Empire Blue Cross and Blue Shield coverage under the Empire Plan.** Under the Empire Plan, Empire Blue Cross and Blue Shield will provide benefits for hospitalization and related expenses as described in this book. The Empire Blue Cross and Blue Shield benefits will be referred to in this section of the book as "this Plan." This book is your Certificate which is evidence of your insurance. You should keep this book with your other important papers so that it is available for your future reference. It is also important for you to be aware of the provisions of your coverage because failure to comply with some of them could result in a reduction in benefits.
2. **Words Empire Blue Cross and Blue Shield uses in this section.** The word "you," "your" or "yours" refers to you, the employee to whom this book is issued, and to any members of your family who are also covered under this Plan.
3. **Who is covered.** Eligibility for coverage is determined under Regulations of the President of the New York State Civil Service Commission. Refer to the General Information section for information on your eligibility for coverage. Also, refer to that section for an explanation of how you enroll in the Empire Plan, which dependents are covered under the Empire Plan and when your coverage becomes effective.
4. **If you are eligible for Medicare.** If you are eligible for primary Medicare coverage, your benefits under this Plan will change. Be sure to read *"Limitations and Exclusions"* on pages 50-53 and *"If You Qualify for Medicare"* on page 55, which describe benefits under this Plan for persons who are eligible for Medicare.
5. **If you are disabled on the date your coverage becomes effective.** If you have a prior confinement in a hospital, skilled nursing facility or other institution for care or treatment immediately preceding the date your coverage under the Empire Plan becomes effective and the confinement continues on the day this Plan becomes effective, or you continue to be confined at home under the care of a physician or surgeon, because of a disabling sickness or injury on the date your coverage under this Plan becomes effective, Empire Blue Cross and Blue Shield will not provide benefits to the extent that you have coverage under any other health care plan, including provisions for benefits after termination in the event of disability. Empire Blue Cross and Blue Shield benefits will be payable only to the extent that they exceed the benefits payable under the other health care plan.
6. **Empire HealthChoice, Inc., doing business as Empire Blue Cross and Blue Shield, is an insurance company organized under the laws of New York State, and is a member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.** It is not acting as agent of the Blue Cross and Blue Shield Association and is solely responsible for honoring its agreement to insure and administer the Empire Plan hospitalization and related expenses coverage.

Benefits Management Program

You must call the Empire Plan Benefits Management Program at 1-800-992-1213

All of the inpatient hospital benefits and skilled nursing facility benefits provided by Empire Blue Cross and Blue Shield under the Empire Plan are subject to the provisions of the Empire Plan's Benefits Management Program. Please read about the Benefits Management Program requirements in the preceding section of this book.

Hospital admission

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

- If you did not call the Benefits Management Program for Pre-Admission Certification of an elective (scheduled) inpatient admission or an admission for the birth of a child, Empire Blue Cross and Blue Shield will apply a $200 hospital deductible. In addition, Empire Blue Cross and Blue Shield will apply a $100-a-day copayment for each day during which it was not medically necessary for you to be an inpatient.
- If you called the Benefits Management Program and did not receive certification for your admission and you are admitted to the hospital as an inpatient for covered services, Empire Blue Cross and Blue Shield will apply a $200 hospital deductible. In addition, Empire Blue Cross and Blue Shield will apply a $100-a-day copayment for each day on which it was not medically necessary for you to be an inpatient. If only a part of your inpatient stay was certified, Empire Blue Cross and Blue Shield will apply a $100 copayment for each non-certified day on which it was not medically necessary for you to be an inpatient.
- If you did not call the Benefits Management Program within 48 hours after an emergency or urgent hospital admission, Empire Blue Cross and Blue Shield will apply a $200 hospital deductible. In addition, Empire Blue Cross and Blue Shield will apply a $100 copayment for each day on which it was not medically necessary for you to be an inpatient.
- If it is determined that you followed the procedures for emergency or urgent admission when you should have followed the Pre-Admission Certification procedures for an elective (scheduled) admission or admission for the birth of a child, Empire Blue Cross and Blue Shield will apply a $200 hospital deductible. In addition, Empire Blue Cross and Blue Shield will apply a $100-a-day copayment for each day on which it was not medically necessary for you to be an inpatient.

Emergency Admission. Emergency admissions apply to medical conditions or acute trauma such that life, limb or the body function of the patient depends on the immediacy of medical treatment. In an emergency admission, the condition requires immediate medical attention, and any delay in receiving treatment would be harmful to the patient. The patient does not have to be admitted via the emergency room to be considered an emergency admission.

Urgent Admissions. Urgent admissions involve medical conditions or acute trauma such that medical attention, while not immediately essential, should be provided very early in order to prevent possible loss or impairment of life, limb or body function.

Maternity Admissions. A maternity admission is one in which a pregnant patient is admitted to give birth. Admissions for incomplete abortion, toxemia and ectopic pregnancy are not considered maternity admissions. These will be considered as either urgent or emergency admissions, and you must call the Benefits Management Program within 48 hours. **Note:** Under New York State Law, effective January 1, 1997, the first 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or the first 96 hours following a cesarean section are presumed to be medically necessary.

If you fail to comply with the requirements of the Benefits Management Program and your hospital admission is not certified, Empire Blue Cross and Blue Shield will only apply the penalties referred to above; your claim will not be denied completely. However, in no case will benefits be paid for services which are contractually excluded, regardless of compliance with the Benefits Management Program provisions. See *"Limitations and Exclusions"* on pages 50-53 for a list of exclusions.

Skilled nursing facility admission

- If you did not call the Benefits Management Program to pre-certify your care in a skilled nursing facility, Empire Blue Cross and Blue Shield will conduct a medical necessity review of your skilled nursing facility stay. You will be responsible for the full charges for each day that it was not medically necessary for you to be in a skilled nursing facility.

Outpatient MRI

- If you did not follow the Prospective Procedure Review requirements for Magnetic Resonance Imaging (MRI), and the procedure was performed in the outpatient department of a hospital, Empire Blue Cross and Blue Shield will conduct a medical necessity review. If the

review does not confirm that the procedure was medically necessary, you will be responsible for the full charges. No benefits will be paid under your Empire Blue Cross and Blue Shield coverage. If you fail to call the Benefits Management Program and Empire Blue Cross and Blue Shield's review confirms that your procedure was medically necessary, but not an emergency, you will be responsible for paying the lesser of 50 percent of the covered hospital charge or $250. You will also be responsible for your $25 hospital outpatient copayment.

Veterans Hospital

If you will be admitted to a medical center or hospital operated by the U. S. Department of Veterans' Affairs, and will be using your Empire Plan benefits, you must comply with the requirements of the Empire Plan Benefits Management Program.

Inpatient Hospital Care

Empire Blue Cross and Blue Shield will pay for your care when you are an inpatient in a hospital or birthing center as described below. Benefits are subject to the requirements of the Empire Plan's Benefits Management Program if the Empire Plan is your primary coverage.

1. **In a hospital.** The term "hospital" means only an institution which meets fully every one of the following criteria:
   - It is primarily engaged in providing on an inpatient basis diagnostic and therapeutic services for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice; *and*
   - It continuously provides 24-hours-a-day nursing service by or under the supervision of registered professional nurses; *and*
   - It is not a skilled nursing facility and it is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.
2. **Hospital services covered.** Empire Blue Cross and Blue Shield will usually pay for all the diagnostic and therapeutic services provided by the hospital. However, the service must be given by an employee of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service. Those services include, but are not limited to:
   - Semi-private room. A semi-private room is a room which the hospital considers to be semi-private. If you occupy a private room, Empire Blue Cross and Blue Shield will only pay the hospital's most common semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.
   - Use of operating, recovery, intensive care and cystoscopy rooms and equipment
   - Laboratory and pathology examinations
   - Basal metabolism tests
   - Use of cardiographic equipment
   - Oxygen and use of equipment for administration
   - Prescribed drugs and medicines
   - Intravenous preparations, vaccines, sera and biologicals
   - Blood and/or blood products, upon satisfactory evidence that local conditions make it necessary to incur expenses for blood or blood products
   - Use of transfusion equipment
   - Dressings and plaster casts
   - X-ray examinations, radiation therapy and radioactive isotopes
   - Chemotherapy
   - Anesthesia supplies, equipment and administration by a hospital staff employee
   - Physiotherapy and hydrotherapy
   - Ambulance service when supplied by the admitting hospital
   - Maternity care for mother and newborn for at least 48 hours after any delivery other than a cesarean section and for at least 96 hours after a cesarean section. Covered hospital maternity care includes parent education, assistance and

training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

You have a paid-in-full benefit for one Maternity Home Care Visit when you choose to be discharged from a hospital or birthing center less than 48 hours after any delivery other than a cesarean section or less than 96 hours after a cesarean section. If you choose early discharge, you must request the Maternity Home Care Visit within 48 hours after any delivery other than a cesarean section or within 96 hours after a cesarean section. The Maternity Home Care Visit will be made within 24 hours of your request or your discharge, whichever is later.

- The full length of your inpatient stay as determined by you and your doctor following lymph node dissection, lumpectomy or mastectomy for treatment of breast cancer.

3. **Birthing center.** Empire Blue Cross and Blue Shield will pay for the hospital services described in Item 2 above for your maternity care in a birthing center which is licensed by the state in which it operates.

See *"Number of Days of Care"* on page 49 for more information.

Outpatient Hospital Care

When you receive the services described in the following sections and subject to the limitations in those sections, Empire Blue Cross and Blue Shield will pay for the same services provided to you in the outpatient department of a hospital as Empire Blue Cross and Blue Shield pays when you are an inpatient in a hospital as described on page 44 under *"Inpatient Hospital Care."* As in the case of inpatient care, the service must be given by an employee of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service.

1. **Emergency Care.** Emergency care is care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
   A. placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy;
   B. serious impairment to such person's bodily functions;
   C. serious dysfunction of any bodily organ or part of such person; or
   D. serious disfigurement of such person.
2. **Surgery.** However, Empire Blue Cross and Blue Shield will not pay for follow-up care for surgery, such as removal of sutures and check-up visits.
3. **Diagnostic radiology, radiation therapy and laboratory tests.** Diagnostic radiology, radiation therapy and laboratory tests will be paid for only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your doctors. You must be physically present at the outpatient department. Payment will not be made for doctors' charges for interpretations of radiology procedures or laboratory tests.
4. **Pre-admission testing.** All of the following conditions must be met:
   A. The tests are ordered by a physician as a preliminary step in your admission to a hospital as a registered bed patient for surgery; *and*
   B. They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; *and*
   C. You have a reservation for the hospital bed and for the operating room before the tests are given; *and*
   D. You are physically present at the hospital when the tests are given; *and*
   E. Surgery actually takes place within 14 days after the tests are given or is canceled as a result of the pre-admission tests.

5. **Physical therapy.** Empire Blue Cross and Blue Shield will pay for physical therapy only when all of the following conditions are met:
   A. The treatments are ordered by your doctor; *and*
   B. The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; *and*
   C. The treatments must start within six months from your discharge from the hospital or within six months from the date outpatient surgery was performed; *and*
   D. No payment will be made for physical therapy given after 365 days from the date you were discharged from the hospital or the date of the surgery.

   You pay a $10 copayment for each visit to the outpatient department of a hospital for physical therapy when covered by Empire Blue Cross and Blue Shield.
6. **Dialysis treatment.** The treatments must be ordered by your doctor.
7. **Chemotherapy.** Empire Blue Cross and Blue Shield pays for chemotherapy. The treatment must be ordered by your doctor. Intravenous chemotherapy, oral chemotherapy, subcutaneous injections and intramuscular injections are covered by Empire Blue Cross and Blue Shield only if the outpatient hospital setting is medically necessary.
8. **Mammography.** Coverage is available under these conditions:
   A. Upon the recommendation of a physician, a mammogram for covered persons at any age having a prior history of breast cancer, or whose mother or sister has a prior history of breast cancer;
   B. A single baseline mammogram for covered persons 35 through 39 years of age;
   C. A mammogram every two years for covered persons 40 through 49 years of age, or more frequently upon the recommendation of a physician;
   D. An annual mammogram for covered persons 50 years of age and older.
9. **Administration of Desferal for treatment of Cooley's Anemia.** This treatment must be ordered by your doctor and must be performed by a hospital qualified to provide this service as determined solely by Empire Blue Cross and Blue Shield.

$35 copayment for emergency care

You must pay the first $35 in charges (copayment) for emergency care in a hospital emergency room. See page 45, *"Outpatient Hospital Care"* for emergency care. Hospitals may require payment of this charge at the time of service.

The $35 emergency room copayment covers use of the facility for **emergency care** *and* services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services. Refer to your United HealthCare Certificate, page 73, *"What is Covered Under the Basic Medical Program (non-participating providers),"* if you receive bills for hospital emergency room service from these providers.

You will not have to pay this $35 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as in inpatient.

$25 copayment for outpatient hospital services

You must pay the first $25 in charges (copayment) for each visit where you receive one or more of the following covered hospital outpatient services, and hospitals may require payment of this charge at the time of service:

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

Only one copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The $25 copayment covers the outpatient facility.

You will not have to pay this $25 facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you at that time as an inpatient.

There is no copayment for the following covered hospital outpatient services:

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

Skilled Nursing Facility Care

Benefits are subject to the requirements of the Empire Plan's Benefits Management Program.

1. **Conditions for skilled nursing facility care.** Empire Blue Cross and Blue Shield 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 transfer from a hospital to a skilled nursing facility.

   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.

2. **Kind of skilled nursing facility.** The facility must be either:

   A. Accredited as a skilled nursing facility by the Joint Commission on Accreditation of Hospitals; or

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

   The New York State Service Center will help you to determine whether a facility qualifies. Refer to page 62, *"Where to Get More Detailed Information"* for the correct address and telephone number.

3. **Covered services.** Empire Blue Cross and Blue Shield will pay the charges of a skilled nursing facility for:

   - a semi-private room. If you occupy a private room, Empire Blue Cross and Blue Shield will pay an amount equal to the facility's most common charge for a semi-private room. You must pay the excess portion of the charge.
   - physical, occupational and speech therapy
   - medical social services
   - the drugs, biologicals, supplies, appliances and equipment furnished for use in the facility and which are ordinarily provided by the facility to inpatients
   - other services necessary for your health which are generally provided by the facility.

See page 49, *"Number of Days of Care"* for more information.

Hospice Care

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

3. **Hospice care covered.** Hospice care is covered during the period when the hospice has accepted you for its hospice program. The following services provided by the hospice organization are covered:
   A. Bed patient care either in a designated hospice unit or in a regular hospital bed.
   B. Day care services provided by the hospice organization.
   C. Home care and outpatient services which are provided by the hospice and for which the hospice charges you. The services may include at least the following:
      1. intermittent nursing care by an R.N., L.P.N. or Home Health Aides
      2. physical therapy
      3. speech therapy
      4. occupational therapy
      5. respiratory therapy
      6. social services
      7. nutritional services
      8. laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms
      9. medical supplies
      10. drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. Empire Blue Cross and Blue Shield will not pay when the drug or medication is of an experimental nature, except as otherwise required by law.
      11. medical care provided by the hospice physician
      12. respite care
      13. bereavement services provided to your family during your illness and until one year after death.

Centers of Excellence for Transplants Program

If you choose to participate in the Centers of Excellence for Transplants Program, you receive enhanced benefits as detailed below. The enhanced benefits include travel reimbursement and a paid-in-full benefit for services covered under the Program and performed at a qualified Center of Excellence. Participation in the Centers of Excellence for Transplants Program is voluntary, but the enhanced benefits under the Program are available only when you are enrolled in the Program, when the Empire Plan is your primary coverage and your transplant services are pre-authorized by Empire Blue Cross and Blue Shield.

Types of transplants

The benefits under the Centers of Excellence for Transplants Program are available for the following types of transplants:

- Bone Marrow
- Peripheral Stem Cell
- Cord Blood Stem Cell
- Heart
- Heart-Lung
- Kidney
- Liver
- Lung
- Simultaneous Kidney-Pancreas

Centers of Excellence

Facilities covered under the Centers of Excellence for Transplants Program include:

- Blue Cross and Blue Shield Association's Blue Quality Centers for Transplant (BQCT), a national network of transplant providers with demonstrated success in achieving positive outcomes

- Facilities in New York State that have been identified by Empire Blue Cross and Blue Shield for their excellence in kidney transplantation

What is covered

You receive paid-in-full benefits for the following services:

- Pre-transplant evaluation
- Inpatient and outpatient hospital and physician care related to the transplant, including 12 months of follow-up care at the center where the transplant was performed. The twelve month period begins on the date of your transplant.

When the above services are pre-authorized by Empire Blue Cross and Blue Shield and provided at a Center of Excellence for Transplants facility, you will not have to make any copayments, and a travel, lodging and meal expenses benefit is available to you. The travel, lodging and meals benefit is available to you and one travel companion when the facility is more than 100 miles from the recipient's home.

Pre-authorization

To receive the paid-in-full benefit and the travel benefit, you must call Empire Blue Cross and Blue Shield at 1-800-342-9815 or 518-367-0009 (from the Albany area and Alaska) to pre-authorize the covered services. To enroll in the Program and receive these benefits, the Empire Plan must be your primary insurance coverage.

Other benefits still available

Since the Centers of Excellence for Transplants Program is voluntary, you are still eligible for Empire Plan benefits for your medically necessary transplant if you do not use the Program. However, you will have to comply with the requirements of the Benefits Management Program and will have to pay any applicable deductible, coinsurance and copayments. You must call Empire Blue Cross and Blue Shield for pre-admission certification of admissions for any of the types of transplants listed above.

Number of Days of Care

Empire Blue Cross and Blue Shield will pay up to 365 benefit days of care for each spell of illness. The days of care may be for inpatient hospital care, maternity care in a birthing center, or skilled nursing facility care.

A spell of illness begins when:

- you are admitted to a hospital or birthing center; or
- you are admitted to a skilled nursing facility.

The spell of illness ends when, for a period of at least 90 days, you have not:

- been a patient in a hospital or birthing center; or
- been a patient in a skilled nursing facility.

A. **Inpatient hospital care.** Each day of inpatient hospital care or care in a birthing center counts as one day of care toward the 365-benefit-day limit.

B. **Skilled nursing facility care.** Each day of care in a skilled nursing facility counts as one-half benefit day of care. For example, 20 days in a skilled nursing facility count as 10 benefit days of care toward the 365-benefit-day limit. To check when benefits will end for care in a skilled nursing facility, contact Empire Blue Cross and Blue Shield. You will not be sent notice.

C. **Outpatient hospital care and hospice care.** Outpatient hospital care is provided whenever you meet the requirements. See pages 45-47 *"Outpatient Hospital Care"* for details. The 365-benefit-day limitation does not apply to outpatient hospital care. Hospice care is provided for the length of time that the hospice has accepted you for its program. The 365-benefit-day limitation does not apply to hospice care. See page 47, *"Hospice Care"* for more information.

Empire Blue Cross and Blue Shield General Provisions

Limitations and Exclusions

What is not covered

You are not covered for benefits by Empire Blue Cross and Blue Shield described on pages 44-49 in *"Inpatient Hospital Care"*, *"Outpatient Hospital Care"*, *"Skilled Nursing Facility Care"*, *"Hospice Care"* or the *"Transplants Program"* for hospitalization or related expenses when any of the following apply to you:

1. **Prior care.** Payment will not be made for services or supplies provided to you before you became covered under the Empire Plan.
2. ***Care must be medically necessary.*** Empire Blue Cross and Blue Shield requires that the service or care you receive be medically necessary. Medically necessary care is care which, according to Empire Blue Cross and Blue Shield criteria, is:
   - consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
   - in accordance with generally accepted medical practices;
   - not solely for your convenience, or that of your doctor or other provider; and
   - the most appropriate supply or level of service which can be safely provided to you.

   Examples of unnecessary care are: when you are admitted to a hospital for care which could have been provided in a doctor's office, or provided without admission to a hospital as a bed patient; when you are in a hospital for longer than is necessary to treat your condition; when hospitalized, you receive ancillary services not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; or when a surgical procedure is performed when a medical treatment would have achieved the desired result.

   In these situations, Empire Blue Cross and Blue Shield's determination of medical necessity will be made after considering the advice of trained medical professionals, which may include physicians, who will use medically recognized standards and criteria. In making the determination, Empire Blue Cross and Blue Shield will examine all of the circumstances surrounding your condition and the care provided, including your doctor's reasons for providing or prescribing the care, and any unusual circumstances.

   The fact that your doctor prescribed the care does not automatically mean that the care qualifies for payments under this Plan.

   However, if an External Appeal Agent, in accordance with the external appeal provisions under *"Filing an Appeal"* on page 59, overturns Empire Blue Cross and Blue Shield's determination that care was medically unnecessary, then Empire Blue Cross and Blue Shield will cover the hospitalization or related expense to the extent that the hospitalization or related expense is otherwise covered under this Certificate.
3. **Eye and hearing care.** Payment will not be made for eyeglasses, contact lenses or hearing aids and examinations for the prescription or fitting of those items.
4. **Cosmetic surgery.** Payment will not be made for services in connection with elective cosmetic surgery which is primarily intended to improve your appearance. However, payment will be made for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the part of the body involved. For a child covered under the Empire Plan, payment will also be made for reconstructive surgery because of congenital disease or anomaly (structural defects at birth) which has resulted in a functional defect.
5. **Custodial care.** Payment will not be made for services rendered in connection with a hospital stay or a portion of a hospital stay in connection with physical check-ups, custodial or convalescent care, rest cures or sanitarium-type care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing,

dressing, eating and taking medicine.

6. **Workers' compensation.** Payment will not be made for care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. *Payments will not be made even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.* Also, payments will not be made even if you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar legislation.
7. **Veterans' facility.** Payment will not be made for services provided in a veterans' facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Empire Plan were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.
8. **War.** Payment will not be made for services for care of illness or injury due to war, declared or undeclared, which occurs after December 5, 1957.
9. **Free care.** Payment will not be made for any care if the care is furnished or would normally be furnished to you without charge. You are not covered for services rendered by a provider for which no legally enforceable charge is incurred.
10. **Medicare.** Payment will be reduced by the amount available to you under the federal government's Medicare program. *When eligible for primary Medicare coverage, you must enroll in Medicare and file for all benefits available to you under Medicare.* Refer to page 55, *"If You Qualify for Medicare"* for further information.
11. **No-Fault automobile insurance.** Payment will not be made for any service which is covered by mandatory automobile No-Fault benefits. However, services not covered under No-Fault, such as when there is a deductible, will be covered by Empire Blue Cross and Blue Shield.
12. **Experimental/investigative procedures.** Empire Blue Cross and Blue Shield will not cover any treatment, procedure, drug, biological product or medical device (hereinafter "technology") or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

    A. not of proven benefit for the particular diagnosis or treatment of your particular condition; or

    B. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

    Empire Blue Cross and Blue Shield will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of your particular condition.

    Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

    Empire Blue Cross and Blue Shield may apply the following criteria in exercising its discretion and may in its discretion require that any or all of the criteria be met:

    - any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device,

drug or biological product for another diagnosis or condition may require that any or all of the criteria be met.

- conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- Empire Plan benefits have been paid or approved by United HealthCare for the technology based on a determination that the technology is covered under the Empire Plan.

This exclusion does not apply to cancer drugs as required by Section 4303(q) of the New York State Insurance Law.

Experimental/Investigational procedures shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See the external appeal provisions under *"Filing an Appeal"* on page 59. If the External Appeal Agent approves coverage of an Experimental or Investigational procedure, only the costs of services required to provide the procedure to you according to the design of the clinical trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

13. **Mental or nervous condition or substance abuse, including alcoholism.** Empire Blue Cross and Blue Shield will not pay for inpatient care for mental and nervous conditions or treatment of alcoholism or substance abuse.

    Empire Blue Cross and Blue Shield will not pay for care of mental and nervous conditions in a day or night care center.

    Empire Blue Cross and Blue Shield will not provide benefits for the outpatient diagnosis or treatment of mental and nervous conditions or alcoholism and substance abuse.

    Empire Blue Cross and Blue Shield will not pay for any skilled nursing facility care or home care in connection with mental or nervous conditions or treatment of alcoholism or substance abuse. Empire Blue Cross and Blue Shield will not pay for ambulance service to and/or from a hospital where you have been or will be receiving treatment for a mental or nervous condition. However, Empire Blue Cross and Blue Shield will pay for ambulance service provided by the admitting hospital when you are transferred there for other than treatment of a mental or nervous condition.

14. **Home Care.** Empire Blue Cross and Blue Shield will not pay for home health care services, including home nursing, home infusion therapy and home health aides. Empire Blue Cross and Blue Shield will not pay for the following services or supplies provided outside a hospital or skilled nursing facility: physical, occupational and speech therapy; prescription drugs; and laboratory services. Exception: home health benefits are available under circumstances outlined in Maternity Care on page 44 under *"Hospital services covered"*.

15. **Infertility Services.** Any hospital inpatient and/or outpatient expenses incurred for

Qualified Procedures under the Infertility Benefit and payable under the Empire Blue Cross and Blue Shield Certificate are subject to the Plan's $25,000 lifetime maximum per covered person.

Empire Blue Cross and Blue Shield will not pay any benefits when prior authorizations have not been obtained for Qualified Procedures as required by the Infertility Benefits included in the United HealthCare Certificate.

16. **Autologous and Directed Blood Donations.** Empire Blue Cross and Blue Shield will not pay for services rendered in connection with the drawing, processing, disposal and/or storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee's own use unless it is medically documented to the satisfaction of Empire Blue Cross and Blue Shield that the enrollee's condition requires the use of autologous or directed blood.

Please refer to the instructions on page 59 under *"Filing an Appeal"* if you wish to appeal a total or partial denial of your claim.

Coordination of Benefits (COB)

Which plan pays first

If you are covered by an additional group health insurance program such as through your spouse's employer, the Empire Plan will coordinate benefit payments with the other program. In this case, one program pays its full benefit as the primary insurer and the other program pays secondary benefits. This prevents duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge.

The Empire Plan does not coordinate benefits with any health insurance policy which you or your dependent carries on a *direct-pay* basis with a *private carrier*.

The procedures followed by Empire Blue Cross and Blue Shield when Empire Plan benefits are coordinated with those provided under another program are detailed below.

1. "Coordination of Benefits" means that the benefits provided for you under the Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payments under the Empire Plan and under another plan are not more than the actual charge for a service which is covered under both group plans.
2. A. "Plan" means a plan which provides benefits or services for or by reason of hospital, medical or dental care and which is:
    1. a group insurance plan; or
    2. a blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
    3. a self-insured or non-insured plan; or
    4. any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
    5. a group service plan; or
    6. a group prepayment plan; or
    7. any other plan which covers people as a group; or
    8. a governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

    B. "Order of Benefit Determination" means the procedure used to decide which plan will determine its benefits before any other plan.

    Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of the Empire Plan which reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts which do not.

3. When coordination of benefits applies and the Empire Plan is secondary, payment under the Empire Plan will be reduced so that the total of all payments or benefits payable under the Empire Plan and under another plan is not more than the actual charge for the service you receive.
4. Payments under the Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a coordination of benefits or similar provision with the same order of benefit determination as stated in Item 5 and under that order of benefit determination, the benefits under the Empire Plan are to be determined before the benefits under the other plan.
5. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules which applies:
    A. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
    B. When this plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are **not** divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph C below.)
        1. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
        2. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
        3. If the other plan does not have the rule described in subparagraphs (1) and (2) above, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
        4. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    C. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
        1. First, the plan of the parent with custody of the child;
        2. Then, the plan of the spouse of the parent with custody of the child; and
        3. Finally, the plan of the parent not having custody of the child; and
        4. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.
    D. The benefits of a plan which covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule D is ignored.
    E. If none of the rules in A through D above determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.
6. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under the Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
7. Any information about covered expenses and benefits, which is needed to apply this provision, may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.

8. If an overpayment is made under the Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
9. If payments which should have been made under the Empire Plan have been made under other plans, the party which made the other payments will have the right to receive any amounts which are considered proper under this provision.

If You Qualify for Medicare

Your Empire Blue Cross and Blue Shield coverage changes when you become eligible for primary coverage under Medicare.

If you or your enrolled dependent is eligible for Medicare at age 65, or because of disability or end stage renal disease, refer to the General Information section of this book for information on which plan provides your **primary** coverage.

If you are eligible for primary coverage under Medicare – even if you fail to enroll – your covered hospital and medical expenses will be reduced by the amount that would have been paid by Medicare, and Empire Blue Cross and Blue Shield will consider the balance for payment under the terms of the Empire Plan.

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare+Choice (Risk) Contract, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained on page 56 under *"Medicare+Choice HMO (formerly Medicare Risk Contract)."*

1. **Retired employees and/or their dependents 65 years of age and older.**

   A. **General.** If you are eligible for Medicare, you must enroll in both Part A (hospitalization and skilled nursing facilities) and Part B (medical services and supplies) of Medicare. **If you are not eligible for Part A of Medicare, you must still enroll in Part B.** You may enroll for Medicare by applying at your local Social Security office.

   B. **Medicare and your Empire Blue Cross and Blue Shield coverage.** Empire Blue Cross and Blue Shield will pay for the following benefits which are not paid for by Medicare:

      1. The initial deductible in each spell of illness.
      2. The coinsurance amount for the 61st through the 90th day of hospital care in each spell of illness.
      3. After you have used the 90 days of hospital care paid for by Medicare, Empire Blue Cross and Blue Shield will pay for additional days of inpatient care in each spell of illness, until Medicare and Empire Blue Cross and Blue Shield have together paid for a total of 365 days of care.

         You also have 60 Medicare reserve days in your lifetime. Each reserve day requires a copayment. You may use the reserve days at any time, including after the 90th hospital day when you are using what remains of your 365 Empire Blue Cross and Blue Shield benefit days. If you use your Medicare reserve days and Empire Blue Cross and Blue Shield benefit days at the same time, Empire Blue Cross and Blue Shield will pay only the copayment. However, each day for which Empire Blue Cross and Blue Shield pays only the copayment applies against the 365 day maximum. Therefore, it is to your advantage to use the reserve days after you have used your 365 Empire Blue Cross and Blue Shield benefit days. Refer to your United HealthCare certificate for information on using your United HealthCare coverage and Medicare reserve days.

   All of the other benefits provided by Empire Blue Cross and Blue Shield under this Plan become available to you after you have exhausted any benefits available to you under Medicare, except for care in a skilled nursing facility.

C. **Payment of Medicare claims.** When admitted to a hospital, always show your New York Government Employee Benefit Card and your Medicare Identification Card. The hospital will then file claims with Medicare and Empire Blue Cross and Blue Shield. You should not be billed for any charges covered under either of these programs.

If the hospital does not deal directly with Empire Blue Cross and Blue Shield, submit the Explanation of Benefits form you received from Medicare to Empire Blue Cross and Blue Shield. Covered expenses will then be processed for payment. See the Filing and Payment of Claims segment of this book to find out which Empire Blue Cross and Blue Shield Plan should receive the claim.

Remember: Bills go to Medicare, then to Empire Blue Cross and Blue Shield.

For more information on Medicare benefits and claims, call Medicare at 1-800-MEDICARE (633-4227) or check the Web site http://www.medicare.gov.

2. **Active employees and/or their dependents.** If you are an active employee or the dependent of an active employee (except for a domestic partner eligible for Medicare due to age), regardless of age, you automatically have full coverage under this Plan unless you make a written election of Medicare to be the primary carrier. In that case, your coverage under this Plan will terminate.

   These benefits will be supplemented by those benefits under Medicare for which you have enrolled. Call your local Social Security office for information on how to file a claim for these supplemental benefits.

   Note for Domestic Partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

   Contact your personnel office or refer to the General Information section for further information.

3. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.

4. **End Stage Renal Disease.** For those eligible for Medicare due to end stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first 30 months of treatment, then Medicare becomes primary. See *"Medicare end stage renal disease coordination"* on page 27 of the General Information section. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

5. **Veterans' Facilities.** If you are eligible for primary coverage under Medicare, and you receive treatment in a U.S. Department of Veterans' Affairs facility or other facility of the federal government which is not eligible for payment from Medicare, the Empire Plan will pay as a secondary coverage, not primary coverage. Empire Plan payment will be calculated as if the services were provided by a non-governmental facility and covered under Medicare. You are not responsible for the cost of services in a governmental facility if those expenses would have been covered under Medicare.

Medicare+Choice HMO (formerly Medicare Risk Contract)

For Medicare-primary Empire Plan enrollees who also enroll in a Health Maintenance Organization under a Medicare+Choice (Risk) Contract. If you or your dependent enrolls in a Health Maintenance Organization under a Medicare+Choice Contract, Empire Blue Cross and Blue Shield will not provide benefits for any services available through your HMO or services that would have been covered by your HMO if you had complied with the HMO's requirements for coverage. Covered medical expenses under the Empire Plan are limited to expenses otherwise covered under the Empire Plan

which are not covered under your Medicare+Choice Contract with the HMO. If your HMO Medicare+Choice Contract has a Point-of-Service option that provides partial coverage for services you receive outside the HMO, covered medical expenses under the Empire Plan are limited to the difference between the HMO's payment and the amount of covered expenses under the Empire Plan.

Termination of Your Empire Blue Cross and Blue Shield Coverage

1. **Termination of eligibility.** Your coverage under this Plan terminates when you are no longer eligible for NYSHIP coverage. Eligibility for coverage is determined under Regulations of the President of the New York State Civil Service Commission. Refer to the General Information section for further information concerning eligibility.

   Under certain conditions, you may be eligible to continue coverage under this Plan. Refer to the General Information section for information concerning this eligibility.

   Your coverage will also terminate if you fail to make your premium payments toward the cost of the Empire Plan, if any are required.
2. **Termination of this Plan.** Your coverage will terminate if the State of New York terminates its contract with Empire Blue Cross and Blue Shield.
3. **Benefits after termination.** If Empire Blue Cross and Blue Shield determines that you are totally disabled from an illness, injury or pregnancy on the date of termination of your coverage, Empire Blue Cross and Blue Shield hospitalization and related expense benefits are available while you are still totally disabled from that illness, injury or pregnancy for expenses incurred within a period of three months after the termination of your coverage, or during a hospital stay which began within that three-month period.

   In no event will you be entitled to receive greater Empire Blue Cross and Blue Shield benefits, or Empire Blue Cross and Blue Shield benefits for a longer period of time, than you would have been entitled to receive if your coverage had not terminated.

Right to New Contract After Termination

If your eligibility for coverage under NYSHIP terminates as described above in Item 1 under "Termination of your Empire Blue Cross and Blue Shield coverage," you may purchase a contract from Empire Blue Cross and Blue Shield under the terms described below.

1. **When to apply for the new contract.** You may apply to Empire Blue Cross and Blue Shield for a direct-payment contract. If you are an employee and your coverage terminates, you should receive a written notice within 15 days which informs you of your right to purchase a direct-payment contract. If you receive the notice more than 15 days after your coverage terminates, you must apply for the new contract within 45 days of receipt of the notice. However, if you do not receive a notice at all, you must apply for the new contract within 90 days after your coverage terminated. If you are a *dependent* and your coverage terminates because you no longer qualify under this Plan as a dependent, you will not receive a written notice. You must apply for the direct-payment contract within 45 days from the date your coverage terminated. Payment of the first premium must be made at the time the direct-payment contract is applied for by either an employee or a dependent.

   If you are Medicare-eligible:

   - If you live in New York State, leave employment and are not eligible to continue the Empire Plan, you may convert your Empire Blue Cross and Blue Shield coverage to a Medicare-supplemental contract by contacting your local Blue Cross Plan.
   - If you live outside New York State, leave employment and are not eligible to continue the Empire Plan, Empire Blue Cross and Blue Shield cannot offer you conversion to direct-payment coverage. Contact the local Blue Cross and Blue

Shield office or other local insurance company in your state to apply for direct-payment coverage.

2. **The new contract**. The direct-payment contract will be a contract which meets, at a minimum, New York State's requirement for basic hospital insurance. It will not provide benefits identical to the Empire Plan.

Miscellaneous Provisions

1. **No assignment.** You cannot assign any benefits or monies due from Empire Blue Cross and Blue Shield to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or organization of your right to the services provided or your right to collect from Empire Blue Cross and Blue Shield for those services.
2. **Your medical records.** In order to process your claims, it may be necessary for Empire Blue Cross and Blue Shield to obtain your medical records and information from hospitals, skilled nursing facilities, doctors, pharmacists or other practitioners who treated you. When you become covered under this Plan, you automatically give Empire Blue Cross and Blue Shield permission to obtain and use those records and that information for the purposes of payment and administration of health care operations. That permission extends to the physicians and other health care personnel with whom we contract to assist us in administering this Plan and reviewing the medical necessity of services covered under this Plan. If we are unable to obtain the medical records, we have the right to deny payment for that claim. The information will be kept confidential.
3. **Recovery of overpayments.** On occasion a payment will be made when you are not covered under this Plan, or for a service which is not covered, or in an amount which is more than is proper. When this happens, the problem will be explained to you and you must return the amount of the overpayment within 60 days.
4. **Right to develop guidelines.** Empire Blue Cross and Blue Shield reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when they will make payment.

   Examples of the use of the criteria are to determine whether hospital inpatient care was medically necessary or whether emergency care in the outpatient department of a hospital was necessary. If you have a question about the criteria which apply to a particular benefit, you may contact Empire Blue Cross and Blue Shield and you will receive an explanation of these criteria.
5. **Time to sue.** You must start any lawsuit against Empire Blue Cross and Blue Shield within two years from the date on which Empire Blue Cross and Blue Shield issued the initial notification that benefits were not available.

Filing and Payment of Empire Blue Cross and Blue Shield Claims

1. **Identification card.** When you receive hospital services, show your New York Government Employee Benefit Card. The hospital will contact Empire Blue Cross and Blue Shield for payment. If you receive hospital services outside of New York State, have the hospital submit its bills to the local Blue Cross Plan and instruct the local Blue Cross Plan to refer the bill to Empire Blue Cross and Blue Shield, Code YLS.

   If you are over 65, or otherwise eligible for Medicare, see *"Payment of Medicare Claims"* on page 55 in the "If You Qualify for Medicare" section for the payment of Medicare claims.
2. **If the hospital does not deal directly with its local Blue Cross Plan:**
   - For services in the United States, the bill is payable to the hospital unless you have already paid the bill. Then Empire Blue Cross and Blue Shield will reimburse you.
   - For services outside of the United States, Empire Blue Cross and Blue Shield will pay you directly.

   Follow the directions below to file your claim:

- If you receive inpatient or outpatient services at a non-member hospital, ask the hospital to file the claim for you.

  If the hospital will not file the claim, you should file the claim directly with the local Blue Cross Plan (the Plan in the area where you received services). Send the local Blue Cross Plan an itemized bill showing the services rendered, the dates on which those services were received, the diagnosis, and your Empire Plan identification number. Instruct the local Blue Cross Plan to refer the bill to Code YLS, Empire Blue Cross and Blue Shield, New York State Service Center, P.O. Box 1407, Church Street Station, New York, New York, 10008-1407. If the bill is for emergency room medical services, you must also include information about the condition or symptoms that led you to seek emergency room treatment.

  Empire Blue Cross and Blue Shield, at its option, will either pay the hospital directly or will reimburse you directly for covered services. The Empire Blue Cross and Blue Shield payment to you is payment in full for covered services, less any applicable copayments or penalties.
- Hospital Outside of the United States - Send an original itemized hospital bill in English or with a translation if possible, and your Empire Plan identification number, to Empire Blue Cross and Blue Shield, New York State Service Center, P.O. Box 1407, Church Street Station, New York, New York, 10008-1407.

  In order to process your claims according to the guidelines of the Empire Plan, Empire Blue Cross and Blue Shield may require medical records. To expedite the processing of your claim, you may wish to obtain copies of your medical records from the hospital when you are discharged. It would be helpful to have these records translated into English, if possible.

  Payment for these services will be calculated based on the rate of exchange (foreign exchange rate) effective on the date of discharge as listed in the Wall Street Journal.
- If assistance is needed in the claims filing process, contact Empire Blue Cross and Blue Shield at 518-367-0009 or 1-800-342-9815.

3. **If Empire Blue Cross and Blue Shield denies your claim for benefits.** If Empire Blue Cross and Blue Shield denies your claim for benefits for a medical procedure or service on the basis that the medical procedure or service is not medically necessary, benefits will be paid by Empire Blue Cross and Blue Shield for covered hospitalization and related expenses if:
   - Another Empire Plan carrier has liability for some portion of the expenses for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service; or
   - Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written pre-authorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the pre-authorization; and
   - You provide to Empire Blue Cross and Blue Shield proof of payment or pre-authorization of benefits from the other Empire Plan carrier regarding the availability of Empire Plan benefits to you for that medical procedure or service.

The above provisions will not prevent Empire Blue Cross and Blue Shield from imposing any penalties that apply for failure to comply with the Empire Plan Benefits Management Program requirements. In addition, the above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

Filing An Appeal

60-day deadline for internal appeal

A request for review must be directed to Empire Blue Cross and Blue Shield, which issued the denial, within 60 days after the day of the notification of adverse decision. You or your authorized representative may request the review in writing or by telephone. When requesting a review you should state the reason why you believe the claim determination or predetermination improperly reduced or denied your benefits. Also, submit additional

details and supporting documentation to justify the appeal of the original determination.

Within fifteen calendar days of receipt of the appeal, Empire Blue Cross and Blue Shield will provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by Empire Blue Cross and Blue Shield to respond to the appeal and what additional information, if any, you must provide in order for Empire Blue Cross and Blue Shield to render a decision.

For a standard appeal, a review will be completed within 30 calendar days. Empire Blue Cross and Blue Shield will provide you or your authorized representative with a written response within two business days after the determination. If the appeal involves a clinical matter, a Health Care Specialist (Registered Nurse) will be responsible for ensuring the appeal is reviewed by an appropriate provider who did not previously review the claim or predetermination request. If the appeal involves an administrative matter, it will be reviewed by a Customer Service Advocate who has been empowered to resolve the appeal.

If additional information is necessary to make a decision, a detailed explanation of the needed information will be requested in writing within 15 calendar days from your provider. You will receive a copy of this request. If only some of the requested information is received, Empire Blue Cross and Blue Shield will notify you within five business days. The final decision (either upheld or overturned) will be communicated to you in writing within 45 business days from the initial receipt date, regardless of whether the requested information is received.

If the determination is upheld, Empire Blue Cross and Blue Shield will send a written response that will indicate the specific Empire Plan provision(s) upon which the determination is based. If the appeal involves a clinical matter, the clinical rationale for the determination will be given. Instructions on how to file a further appeal will be included in that correspondence.

Expedited Appeal: If you are appealing a decision as to the medical necessity of your service(s) and your appeal involves a situation in which your provider believes a delay would significantly increase a risk to the patient's health or if the patient is in the middle of a course of treatment, the appeal will be resolved within two business days from receipt of all necessary information. Empire Blue Cross and Blue Shield will notify the enrollee or the enrollee's authorized representative by telephone immediately of the determination. Additionally, written notice will be sent within 24 hours following the determination.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, Agency Building One, Empire State Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9am - 5pm.

External Appeal

Your right to an External Appeal. Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Empire Blue Cross and Blue Shield has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary. If you have been denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following two criteria:

A. The service, procedure or treatment must otherwise be a Covered Service under the Certificate; and

B. You must have received a final adverse determination through the internal appeal process described above and Empire Blue Cross and Blue Shield must have upheld the denial **or** you and Empire Blue Cross and Blue Shield must agree in writing to waive any internal appeal.

Your right to appeal a determination that a service is experimental or investigational. If you have been denied coverage on the basis that the service is an

experimental or investigational treatment, you must satisfy the following two criteria:

A. The service must otherwise be a Covered Service under the Certificate; and

B. You must have received a final adverse determination through the internal appeal process described above and Empire Blue Cross and Blue Shield must have upheld the denial or you and Empire Blue Cross and Blue Shield must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service. Only certain documents will be considered in support of this recommendation. Your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable; or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process. If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Empire Blue Cross and Blue Shield have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. Empire Blue Cross and Blue Shield will provide an external appeal application with the final adverse determination issued through Empire Blue Cross and Blue Shield's internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Empire Blue Cross and Blue Shield based its denial, the External Appeal Agent will share this information with Empire Blue Cross and Blue Shield in order for it to exercise its right to reconsider its decision. If Empire Blue Cross and Blue Shield chooses to exercise this right, Empire Blue Cross and Blue Shield will have three business days to amend or confirm its decision. Please note that in the case of an expedited external appeal (described below), Empire Blue Cross and Blue Shield does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or Empire Blue Cross and Blue Shield. If the External Appeal Agent requests additional information, it will have five additional

business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Empire Blue Cross and Blue Shield by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision. If the External Appeal Agent overturns Empire Blue Cross and Blue Shield's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, Empire Blue Cross and Blue Shield will provide coverage subject to the other terms and conditions of the Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Empire Blue Cross and Blue Shield will only cover the costs of services required to provide treatment to you according to the design of the trial. Empire Blue Cross and Blue Shield shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Certificate for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Empire Blue Cross and Blue Shield. The External Appeal Agent's decision is admissible in any court proceeding.

Empire Blue Cross and Blue Shield will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. Empire Blue Cross and Blue Shield will waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibility in filing an External Appeal

It is YOUR RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

45-day deadline for external appeal

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from Empire Blue Cross and Blue Shield that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. Empire Blue Cross and Blue Shield has no authority to grant an extension of this deadline.

Where to Get More Detailed Information

If this book does not answer the questions you may have about your Empire Blue Cross and Blue Shield coverage, contact:

Empire Blue Cross and Blue Shield
New York State Service Center
P.O. Box 1407, Church Street Station
New York, New York 10008-1407

518-367-0009 Albany area and Alaska; 1-800-342-9815 New York State and other states except Alaska

TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-241-6894

If you are unable to obtain the information you need, or if you are a retired State employee, you may get in touch with:

State of New York Department of Civil Service
Employee Benefits Division

CERTIFICATE OF INSURANCE

for
eligible enrollees
of

State of New York

(called the State)

insured by

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

Hauppauge, New York

(called United HealthCare)

United HealthCare Insurance Company of New York has issued Group Policy Nos. 30500-G, 30501-G and 30502-G. They insure certain eligible enrollees covered by the Empire Plan.

This Certificate of Insurance describes the benefits and provisions of the policy. This is a covered person's Certificate of Insurance only while that person is insured under the policy. Dependent benefits apply only if the eligible enrollee is insured under the Empire Plan for Dependent Benefits.

This Certificate describes the Plan in effect on the later of:

(i) January 1, 2001 and

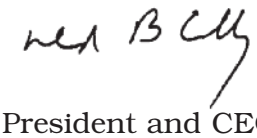
(ii) the date determined in accordance with the Regulations of the President of the Civil Service Commission

for Active Employees and their Dependents enrolled through Participating Employers and for COBRA enrollees with their benefits. It is void if issued to any other Employee.

This Certificate replaces any and all Certificates previously issued to eligible enrollees under the Plan.

The insurance evidenced by this Certificate meets the minimum standards for basic medical insurance as defined by the New York State Insurance Department. It does not provide basic hospital insurance or mental health/substance abuse insurance.

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK



President and CEO

Form No. 8048

United HealthCare

Section III:
UNITED HEALTHCARE
CERTIFICATE OF INSURANCE

Participating Provider Program
Basic Medical Program
Home Care Advocacy Program
Managed Physical Medicine Program
Infertility Benefits

The Empire Plan includes the Participating Provider Program, the Basic Medical Program, the Home Care Advocacy Program (HCAP), the Managed Physical Medicine Program and Infertility Benefits. The following describes these programs.

The Empire Plan was designed to provide you with comprehensive medical care coverage and to do so in such a way as to curb rising health care costs. To receive the highest level of benefits, be sure you understand each of these programs.

Plan Overview

Medical coverage for most services is under the Participating Provider Program and the Basic Medical Program (covering non-participating providers). The following information will give you an overview of how these two parts work to provide benefits for covered services.

You choose:

A Participating Provider

You pay only the copayment. (Some services require no copayment.)

Basic Medical Program (A Non-Participating Provider)

Before your covered expenses can be reimbursed, you must meet an annual medical deductible. If you have Family coverage, your enrolled spouse/domestic partner must meet an annual deductible. All your enrolled children, combined, must meet an annual deductible. Please do not send claims to United HealthCare until the annual deductible is satisfied.

You submit claims to United HealthCare. The Empire Plan reimburses you 80 percent of the reasonable and customary charges for covered services, or the actual billed charges, whichever is less.

You pay the remaining 20 percent (coinsurance) until you and your family meet the coinsurance maximum. You also pay any charges above the reasonable and customary amount.

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

Participating providers

1. Participating providers have agreed to accept a schedule of allowances, including any copayment, for their services. When you use a participating provider, you pay the provider your copayment for covered services and United HealthCare pays the provider in accordance with the schedule of allowances. You do **not** have to pay the participating provider for remaining charges for covered services or submit a claim form. You sign a claim form, the provider sends it to United HealthCare, and United HealthCare sends you an explanation of benefits form telling you what benefits the participating provider received.

   Using participating providers is convenient for you and helps keep the cost of the Empire Plan at a reasonable level.

Basic Medical (Non-participating providers)

2. The second portion of this Plan is the **Basic Medical Program.** When you use a non-participating provider, you are responsible for paying the provider's charges, and must submit a claim for benefits due you. You are liable for an annual deductible, for a percentage of covered medical expenses in excess of the deductible, for any charges above the reasonable and customary amount, and for any penalties incurred under the benefits management programs. See page 89, *"How, When and Where to Submit Claims"* for information on how to submit Basic Medical claims.

The Benefits Management Program requirements apply, if the Empire Plan is primary

Please refer to the section of this book on the Empire Plan's Benefits Management Program. Also refer to the sections of this certificate on HCAP, the Managed Physical Medicine Program, and Infertility Benefits. Make sure you understand the steps you must take for each program in order to receive maximum benefits.

Your benefits under both the Participating Provider Program and the Basic Medical Program can be affected by the requirements of the Benefits Management Program.

Hospital admission

If you have a hospital admission which is covered under this Plan, you must comply with the **Pre-Admission Certification** requirements. If you do not comply, you may be subject to paying a $200 inpatient deductible and a $100 copayment for each day it is determined that your hospitalization is not medically necessary.

Outpatient MRI

If you have Magnetic Resonance Imaging (MRI), a test requiring **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 75. If you do not comply with PPR requirements and United HealthCare's review does not confirm that the MRI was medically necessary, you will be responsible for the full charges. *Read the "Benefits Management Program" section for complete information.*

HCAP requirements apply even if Medicare is primary

If you need home nursing services, home infusion therapy and/or durable medical equipment/supplies, you must comply with the requirements of the Home Care Advocacy Program (HCAP), even if Medicare is your primary coverage. When you follow HCAP requirements, you will have a paid-in-full benefit. If you do not comply, non-network benefits will apply for medically necessary services: you must pay for the first 48 hours of private duty nursing per calendar year. You must meet the Basic Medical Program annual deductible and you will be reimbursed up to 50 percent of the HCAP Network Allowance. Read the *"Home Care Advocacy Program"* section on pages 76-80 for complete information.

MPN requirements apply even if Medicare is primary

To receive network benefits, the highest level of benefits for chiropractic treatment or physical therapy, you must comply with the requirements of the Managed Physical Medicine Program, administered by Managed Physical Network, Inc. (MPN). When you choose MPN providers, you pay only a $10 copayment. When you use non-network providers, you pay a

much higher share of the cost unless MPN has made arrangements for you because no network providers are available in your area. Under non-network coverage, you are liable for an annual deductible, for a percentage of covered medical expenses in excess of the deductible and for any charges above your maximum annual benefit. Read the *"Managed Physical Medicine Program"* section on pages 80-81 for complete information.

Infertility Benefits requirements apply, even if Medicare is primary

Special benefits and requirements apply for Empire Plan Infertility Benefits. For infertility treatment, you must call United HealthCare for prior authorization of certain Qualified Procedures, regardless of provider or where the procedure is performed. Authorized Qualified Procedures are covered up to a lifetime maximum of $25,000. When care is authorized at a participating Center of Excellence, you have paid-in-full benefits. Read the *"Infertility Benefits"* section beginning on page 82 for complete information.

Meaning of Terms Used

Throughout this certificate, the meaning of these terms is limited to these definitions:

A. **This Plan** means the medical expense coverage provided under Group Policy Nos. 30500-G and 30501-G issued to the State of New York by United HealthCare.

B. The word **You** as used in this Plan means you, the enrollee, and you, an eligible dependent member of the enrollee's family. **Enrollee** and **Dependent** are defined in the NYSHIP General Information Book.

C. **Provider** means any Doctor, Dentist, Nurse, Chiropractor, Certified Nurse Midwife, Optometrist, Physical Therapist, Speech Therapist, Occupational Therapist, Speech-Language Pathologist, Audiologist, Podiatrist, Laboratory, Ambulatory Surgical Center, Visiting Nurse Service, Home Health Care Agency or facility legally licensed to perform a covered medical service.

D. **Hospital** is defined in the Empire Blue Cross and Blue Shield section of this book; **Doctor** means a person legally licensed to practice medicine or osteopathy; **Dentist** means a person legally licensed to practice dentistry; and **Nurse** means a registered professional nurse (R.N.).

E. **Participating Providers** are those eligible providers who have an agreement in effect with United HealthCare to accept your copayment plus payment directly from United HealthCare, in accordance with the Empire Plan schedule of allowances, as payment-in-full for covered medical services under the **Participating Provider Program.** Exceptions to payment-in-full under the program are detailed in the Benefits Management Program section and under Infertility Treatment benefit.

Home Care Advocacy Program (HCAP) Providers are those eligible providers who have an agreement in effect with United HealthCare to provide home nursing services, home infusion therapy and/or durable medical equipment or supplies under the Home Care Advocacy Program.

F. **Schedule of Allowances** means United HealthCare's schedule of amounts it will pay to Empire Plan participating providers for covered medical services.

G. A **Non-Participating Provider** is one who has **not** entered into an agreement with United HealthCare to accept payment in accordance with the schedule of allowances for covered medical expenses under this Plan. You are responsible for paying a non-participating provider's charges. To receive reimbursement for such charges you must file a claim with United HealthCare. **The fees charged by a non-participating provider may exceed the amount reimbursed by United HealthCare.**

H. **MPN Network Providers** are those eligible providers who have an agreement in effect with Managed Physical Network, Inc. (MPN) to accept your copayment plus the MPN Network Allowance as payment in full for chiropractic treatment and physical therapy under the Managed Physical Medicine Program.

I. **MPN Network Allowance** means the amount MPN Network providers have agreed to accept as payment in full for services they render to you, including your copayments, under the Managed Physical Medicine Program.

J. **An MPN Non-Network Provider** is one who has **not** entered into an agreement with Managed Physical Network, Inc. (MPN) to accept payment in accordance with the MPN Network Allowance under the Managed Physical Medicine Program for chiropractic treatment or physical therapy. You are responsible for paying a non-network provider's charge. To receive reimbursement for such charges you must file a claim with United HealthCare. **The fees charged by a non-network provider may exceed the amount reimbursed by United HealthCare.**

K. **HCAP Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you.

L. **HCAP Non-network Allowance** means the lower of the following:

- the amount you actually paid for a medically necessary service, equipment or supply covered under HCAP; or
- 50 percent of the HCAP network allowance for such service, equipment or supply.

The HCAP non-network allowance for a home care service, durable medical equipment or supply is determined by United HealthCare and applied according to established guidelines. The non-network allowance is used by United HealthCare as a basis for determining the amount of benefits you are entitled to receive under non-network coverage.

M. An **HCAP Non-Network Provider** is one who has **not** entered into an agreement with United HealthCare to accept payment in accordance with the HCAP Network Allowance under the Home Care Advocacy Program. You are responsible for paying a non-network provider's charge. To receive reimbursement for such charges you must file a claim with United HealthCare. **The fees charged by a non-network provider may exceed the amount reimbursed by United HealthCare.**

N. **Medically Necessary or Medical Necessity** means health care services and supplies which are determined by United HealthCare to be medically appropriate and:

1. necessary to meet your basic health needs;
2. rendered in the least intensive and most appropriate setting for the delivery of the service or supply;
3. consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies that are accepted by United HealthCare;
4. consistent with the diagnosis of the condition;
5. required for reasons other than the comfort or convenience of you or your Doctor;
6. demonstrated through prevailing peer-reviewed medical literature to be either:
    a. safe and effective for treating or diagnosing the sickness or condition for which their use is proposed, or,
    b. safe with promising efficacy
        (i). for treating a life-threatening sickness or condition,
        (ii). in a clinically-controlled research setting, and
        (iii). using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a doctor has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is Medically Necessary as defined above. The definition of Medically Necessary used in this Certificate relates only to coverage and differs from the way in which a Doctor engaged in the practice of medicine may define medically necessary.

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, except as otherwise provided, due to your sickness, injury or

pregnancy. A covered medical expense is incurred on the date the service or supply is received by you. In order for a charge to be a covered medical expense, the service must be performed by a provider as defined in paragraph C above.

Charges for a service performed 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 be performed 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 and supplies must be medically necessary as defined in this section. No more than the reasonable and customary charge for medical services will be covered by the Plan. *A more detailed description of* ***covered expenses*** *and* ***exclusions*** *follows.*

P. **Reasonable and Customary Charge** means the lowest of:

1. the actual charge for a service or supply; or
2. the usual charge by the doctor or other provider for the same or similar service or supply; or
3. the usual charge of other doctors or other providers of similar training or experience in the same or similar geographic area for the same or similar service or supply.

The determination of the reasonable and customary charge for a service or supply is made by United HealthCare.

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

Q. **Deductible** means the amount you must pay for covered medical expenses each calendar year before benefits will be paid under the **Basic Medical** portion of this Plan. There is **no deductible** for benefits paid through the Participating Provider portion of this Plan. The Basic Medical annual deductible is separate from other plan deductibles, including the Managed Physical Medicine Program for non-network services and the Mental Health and Substance Abuse Program deductibles for non-network services.

R. **Calendar Year** means the period beginning with January 1 and ending with December 31.

S. **Coinsurance** means the difference between the reasonable and customary charge and the covered percentage under the **Basic Medical** portion of this 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.

T. 1. Under the Participating Provider Program, the **covered percentage** is **100 percent** of the schedule of allowances, including your copayment.

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 except:

   a. as provided on page 76 under *"Prospective Procedure Review: MRI"*; on page 76 under the "*Home Care Advocacy Program*"; on page 81 under *"Guaranteed access"* for the Managed Physical Medicine Program and on page 82 under *"Infertility Benefits"*; *and*

   b. **The covered percentage** becomes **100 percent** of the reasonable and customary charge once the combined coinsurance amount for you, the enrollee, and your covered dependents exceeds $1,247 in calendar year 2001. 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 the Urban Wage Earners and Clerical Workers, all cities (C.P.I.-W.) for the period July 1 through June 30 of the preceding year.

The 20 percent coinsurance you pay for covered services by non-participating providers counts toward this $1,247 **coinsurance maximum.** Your copayments for services by participating providers also count. (However, the copayments do not stop when you reach the coinsurance maximum.)

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

Once you meet the coinsurance maximum, you will be reimbursed at 100 percent of the reasonable and customary amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the reasonable and customary amount and any penalties under the benefits management programs.

3. For Infertility Benefits, expenses are paid the same as for other medical conditions: the covered percentage for Basic Medical Program services is 80 percent of the reasonable and customary charges. Under the Participating Provider Program, the covered percentage is 100 percent of scheduled allowances after your copayments. However, you have no copayment at an Infertility Center of Excellence. Certain benefits are subject to a lifetime maximum as indicated in the section titled *"Infertility Benefits"* (see pages 82-83).

U. **Outpatient** means that covered medical expenses are incurred in a doctor's office, in the outpatient department of a hospital or in an ambulatory facility.

V. **Inpatient** means covered medical expenses are incurred during confinement for which a room and board charge is made by a hospital.

W. The **Annual Maximum** of the Basic Medical portion of this Plan is unlimited. The Annual Maximum for non-network services under the Managed Physical Medicine Program is $1,500 per covered person.

X. The **Lifetime Maximum** of the Basic Medical portion of this Plan and the Managed Physical Medicine Program is unlimited. The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is $25,000 per covered person under the Empire Plan hospital and medical programs.

Y. **Emergency Care** is care received for an emergency condition. An emergency condition is a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

   a. placing the health of the person afflicted with such condition in serious jeopardy:
   b. serious impairment to such person's bodily functions;
   c. serious dysfunction of any bodily organ or part of such person; or
   d. serious disfigurement of such person.

Z. Your **Copayment** is the first $10 which you are required to pay for certain services by participating providers and MPN Network Providers, or the first $15 in a participating ambulatory surgical center.

AA. An **Urgent Care Center** is a facility staffed by medical professionals that include physicians and nurses, with evening and weekend hours. It provides services for acute and uncomplicated problems without the need for an appointment.

BB. A **Spell of Illness** begins when you are admitted as a patient to a hospital, birthing center or skilled nursing facility or receive home health care. When you are no longer a patient or receiving home health care for a period of at least 90 days for the same illness, the spell of illness ends, and benefits are available to you again starting with the date of your new spell of illness.

Participating Provider Program

The Participating Provider Program of the Empire Plan is described in this portion.

Your out-of-pocket expenses are lower when you choose participating providers

You pay only your $10 copayment for office visits, surgical procedures performed during an office visit, radiology services, diagnostic laboratory services and visits to a cardiac rehabilitation center or to an urgent care center when they are covered under the Participating Provider Program. You pay only your $15 copayment for facility charges, including anesthesiology, at a **participating ambulatory surgical center.** There is no cost to you for some services covered under the Participating Provider Program.

Finding Participating Providers

To learn whether a doctor, specialist, laboratory, ambulatory surgical center, cardiac rehabilitation center or urgent care center is an Empire Plan participating provider, check with the provider directly or call United HealthCare at 1-800-942-4640. Or, visit the New York State Department of Civil Service Web site at http://www.cs.state.ny.us. Click on Employee Benefits, then on Empire Plan Providers and follow the instructions.

Extended Network: The Directory also lists physicians in the following six states who are in the United HealthCare Options PPO network and have agreed to participate in the Empire Plan: Arizona, Connecticut, Florida, New Jersey, North Carolina and South Carolina. Ask physicians in these states if they are in the United HealthCare Options PPO network and tell them you are covered by the Empire Plan. In all other states including New York, and for providers other than physicians in these six states, ask if the provider participates in the Empire Plan.

When you use a participating provider, United HealthCare will pay for the covered medical services listed below. You must advise the participating provider of your Empire Plan coverage **before** you receive services. Benefits are automatically assigned and United HealthCare will pay the participating provider directly in accordance with the schedule of allowances. By using participating providers, you minimize your out-of-pocket expenses.

You have the freedom to choose any participating provider without a referral. However, there is no guarantee a participating provider will always be available to you. The Empire Plan does not require that a participating provider send you to a participating specialist, laboratory, radiologist or center. Ask for a participating provider and ask that samples be sent to a participating laboratory. It is always your responsibility to determine whether a provider is an Empire Plan participating provider.

When you use a non-participating provider, covered benefits are payable under the Basic Medical portion of the Plan, so your out-of-pocket expenses are usually higher.

What is covered under the Participating Provider Program

The following **covered medical services** are included in the Participating Provider Program. After you pay your copayment (if any), charges for these services will be paid directly to the participating provider you have chosen. You do **not** pay these charges yourself.

A. **Office and Home Visits** — You are covered for doctor's office visits and home visits by a doctor for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-child care. General medical care includes routine pediatrics and physical exams. The cost of oral and injectable substances for routine preventive pediatric immunizations is covered. Some immunizations for adults also are covered (see next page for a list).

There is no copayment for well-child office visits, including routine pediatric examinations, pediatric immunizations and the cost of oral and injectable substances, according to prevailing clinical guidelines.

There is no copayment for professional services for allergy desensitization when billed by a participating provider. If there is an associated office visit, a copayment will apply.

There is no copayment for covered outpatient services provided in the outpatient department of a hospital by a participating provider.

B. **In-Hospital Doctor's Visits** — You are covered for doctor's visits while an inpatient in a hospital if such visits are not related to surgery. Benefits for visits related to surgery are included in the scheduled amount for the surgery.

C. **Podiatry** — You are covered for the services of a podiatrist **except** for routine care of the feet.

D. **Specialist Consultations** — Your doctor may refer you to a specialist for a consultation. During the consultation, the specialist will evaluate your medical condition and give you and your doctor professional advice on how to proceed with your care.

You are covered for one **out-of-hospital** consultation in each specialty field per calendar year for each condition being treated. You are covered for one **in-hospital** consultation in each specialty field, per confinement, for each condition being treated.

You are **not** covered for consultations in the fields of pathology, roentgenology or anesthesiology.

E. **Adult Immunizations** — You pay a $10 copayment for influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chicken pox) and tetanus immunizations.

F. **Routine Mammograms** — In addition to mammograms performed when a medical condition is suspected or known to exist, you are covered for mammograms performed as part of routine preventive care under these conditions:

- upon the recommendation of a physician, a mammogram for covered persons at any age having a prior history of breast cancer, or whose mother or sister has a prior history of breast cancer;
- a single baseline mammogram for covered persons 35 through 39 years of age;
- a mammogram every year for covered persons 40 years of age and older, or more frequently upon the recommendation of a physician.

G. **Ambulatory Surgical Center** — You pay a $15 copayment for facility charges at a freestanding ambulatory surgical center that has an Empire Plan agreement in effect with United HealthCare on the date of your elective surgery. This copayment includes anesthesiology, radiology and laboratory tests performed at the ambulatory surgical center on the same day as the surgery. You pay an additional $15 copayment for pre-operative testing performed on a different day from the surgery. Surgeons charges are billed separately and covered under either the Participating Provider or Basic Medical Program provisions.

H. **Cardiac Rehabilitation Center** — If your doctor prescribes cardiac rehabilitation, you pay a $10 copayment for each visit to a freestanding cardiac rehabilitation center that has an Empire Plan agreement in effect with United HealthCare on the date of your visit. This copayment includes use of the facility and services you receive from nurses and doctors who monitor the program. There is no copayment for visits to a hospital-based cardiac rehabilitation center that has an Empire Plan agreement in effect with United HealthCare on the date of your visit.

I. **Urgent Care Center** — You pay a $10 copayment for medically necessary visits to and services provided at an Urgent Care Center.

J. **Surgery** — You are covered for the services of a doctor for surgery, including post-operative care, whether performed in or out of a hospital.

In the same visit, if you have an office visit charge and an office surgery charge, only one copayment will apply.

K. **Reconstructive Surgery** — You are covered for the services of a doctor for:

- Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:
  - Birth defect
  - Sickness
  - Accidental injury
- Reconstructive breast surgery following a medically necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following the mastectomy)

- Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other medically necessary surgery.

L. **In-Hospital Anesthesia** — You are covered for anesthesia services if such services are performed in connection with in-hospital surgery or maternity care. You are **not** covered if the anesthesia services are administered by your doctor, by your doctor's assistant or by a hospital employee.

M. **Diagnostic Laboratory and Radiology** — You are covered for diagnostic laboratory and radiology procedures performed out of a hospital. You are also covered for the separate interpretation of radiology procedures by a radiologist if the radiologist bills separately.

If outpatient diagnostic laboratory tests and outpatient radiology procedures are charged by a participating provider during a single visit, only one copayment will apply.

N. **Infertility Treatment** — See pages 82-83, *"Infertility Benefits"* for information regarding benefits for the treatment of infertility.

O. **Maternity Care** — You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, and for complications of pregnancy. United HealthCare's payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided.

Maternity care may be rendered by a doctor or by a licensed or certified nurse midwife. The nurse midwife must be:

1. licensed or certified to practice nurse midwifery; and
2. permitted to perform the service under the laws of the state where the services are rendered.

There is no copayment for prenatal visits, delivery and the six-week check-up after delivery.

P. **Speech Therapy** — You are covered for the services of a speech therapist or speech-language pathologist when:

1. such services are prescribed and supervised by your physician:
2. treatment is medically necessary; and
3. the provider is currently licensed in the state where the service is rendered.

Q. **Radiation Therapy** — You are covered for radiation therapy given in or out of a hospital.

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.

Basic Medical Program

If you incur covered medical expenses and do not use a participating provider, your benefits for most services will be determined under the Basic Medical portion of this Plan. This section describes your coverage under the Basic Medical Program, and how the program works.

Also refer to the sections of this certificate on the Home Care Advocacy Program and Managed Physical Medicine Program. Benefits for certain services are determined under these programs, not under the Basic Medical Program.

Assignment of benefits to a non-participating provider is not permitted. (Assignments will be made to hospitals. Assignments will also be made for ambulance services as long as the ambulance service has a contract in effect with United HealthCare.)

You must meet a deductible and pay 20% coinsurance when you choose non-participating providers

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:

a. First, you are liable for the deductible. It is your responsibility.

b. After the deductible, covered medical expenses are considered for payment. United HealthCare will reimburse you for 80 percent of the reasonable and customary charges for covered services, or actual billed charges, whichever is less. You pay the balance of 20 percent (coinsurance) and any charges above the reasonable and customary amount. The covered percentage becomes 100 percent of the reasonable and customary charge once the combined coinsurance amount for you and your covered dependents exceeds the coinsurance maximum in a calendar year.

Details of the annual deductible and how it works, and your covered medical expenses, are described on the following pages.

1. **Annual Deductible**

   For calendar year 2001, the Basic Medical annual deductible for medical services by non-participating providers is $259 for the enrollee, $259 for the enrolled spouse/domestic partner, and $259 for all dependent children combined. The Basic Medical annual deductible is adjusted 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.

   Before your claims can be reimbursed, you must meet the deductible.

   The Basic Medical annual deductible cannot be combined with the Managed Physical Medicine Program annual deductible for non-network services or with the Mental Health and Substance Abuse Program annual deductibles for non-network services.

2. **Coverage**

   United HealthCare 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 amount.**

3. **Covered Basic Medical Expenses**

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

What is covered under the Basic Medical Program (non-participating providers)

Under the Basic Medical Program, covered medical expenses include charges for the following services or supplies:

A. **Hospitals**

1. Services of **hospitals for which Empire Blue Cross and Blue Shield benefits are provided** are covered excluding:

   a. charges for room and board and special services provided to you as an inpatient during a period for which Empire Blue Cross and Blue Shield benefits are provided;

   b. any room and board charges in excess of the hospital's most common semi-private room rate, if a private room is used;

   c. charges for outpatient services covered by Empire Blue Cross and Blue Shield;

   d. services not billed for by the hospital; and

   e. expenses for private duty nursing services while you are an inpatient.

Remember: You must comply with the requirements of the hospital and medical Benefits Management Program for a hospital admission. Refer to the details of how this program works in the Benefits Management Program section of this book.

If and when it is determined that inpatient care is no longer medically necessary, benefits will cease and notice will be given to the hospital and patient the day before your benefits end.

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

B. **Hospital Emergency Room** — If Empire Blue Cross and Blue Shield determines that you received emergency care in a hospital Emergency Room, covered charges billed separately by the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electro-cardiograms, and/or pathology services,will be paid in full by United HealthCare.

Services provided by other specialty physicians in a hospital Emergency Room are considered under the Participating Provider Program or the Basic Medical Program depending on whether the physician participates.

C. **Doctors** — Services of doctors are covered.

D. **Nurse Midwife Services** — Maternity services of a nurse midwife are covered if the nurse midwife is:

   a. licensed or certified to practice nurse midwifery; and

   b. permitted to perform the service under the laws of the state where the services are rendered.

E. **Podiatrists** — Services of duly licensed podiatrists for the treatment of (i) diseases, (ii) injuries and (iii) malformation of the foot are covered, **except** that those treatments or supplies listed in Items P and Q of the Exclusions segment are **not** covered medical expenses. See *"United HealthCare General Provisions: Exclusions"* on page 83.

F. **Routine Health Exams for Active Employees** — Routine health exams are covered for you, the active employee, if you are age 50 or older, up to a maximum reimbursement of $250 per calendar year; for an active employee's covered spouse/domestic partner, age 50 or older, routine health exams are covered up to a maximum reimbursement of $250 per calendar year. *These benefits are not subject to deductible or coinsurance.*

G. **Routine Newborn Child Care** — Doctors' services for the routine care of a newborn child are covered up to a total maximum payment of $150. *These benefits are not subject to deductible or coinsurance.*

H. **Routine Pediatric Care** — Routine well-child care is covered for children up to age 19 including examinations, immunizations and the cost of oral and injectable substances, according to pediatric care guidelines.

I. **Mammograms as Part of Routine Preventive Care** — In addition to mammograms performed when a medical condition is suspected or known to exist, you are covered for routine mammograms according to the same guidelines as the *"Participating Provider Program"* (page 71). However, in the absence of a diagnosis, the corresponding office visit fee is not covered.

J. **Ambulance Service** — The following ambulance services are covered medical expenses:

   a. Local professional (commercial) ambulance charges except for the first $35. *These amounts are not subject to deductible or coinsurance.*

   b. Donations made to an organized voluntary ambulance service up to a maximum of $50 for services under 50 miles, $75 for 50 miles or over. *These amounts are not subject to deductible or coinsurance*

K. **Cardiac Rehabilitation Center** - Medically necessary visits to a cardiac rehabilitation center are covered when prescribed by a doctor.

L. **Urgent Care Center** — You are covered for medically necessary visits to and services provided at an urgent care center.

M. **Ambulatory Surgical Center** — You are covered for medically necessary facility charges at a freestanding ambulatory surgical center.

N. **Reconstructive Surgery** — You are covered for reconstructive surgery under the same conditions as the Participating Provider Program.

O. **Prosthetics** — Artificial limbs or other prosthetic devices, including replacement when it is functionally necessary to do so, are covered.

P. **Eye Care Following Cataract Surgery** — The charges for one pair of prescription eyeglasses or one contact lens and one eye examination are covered medical expenses per affected eye per cataract surgery.

Q. **Mastectomy Bras** — When prescribed by a physician, mastectomy bras, including replacements when functionally necessary to do so, are covered.

R. **Hearing Aids** — Effective January 1, 2001, hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of $1,000 once every four years. Children age 12 years and under are eligible to receive a benefit of up to $1,000 once every two years when it is demonstrated that a covered child's hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child's hearing loss. *These benefits are not subject to deductible or coinsurance.*

S. **Infertility Treatment** — See pages 82-83 *"Infertility Benefits"* for information regarding benefits for the treatment of infertility.

T. **Voluntary Sterilization** — Charges for voluntary sterilization are covered medical expenses.

U. **Miscellaneous Services** — The following services are covered under the Basic Medical Program when not covered by Empire Blue Cross and Blue Shield:

   a. Diagnostic laboratory procedures and radiology
   b. X-ray or radiation treatments
   c. Oxygen and its administration
   d. Anesthetics and their administration except when performed by your doctor or your doctor's assistant
   e. Blood transfusions, including the cost of blood and blood products; however, such costs will be covered medical expenses only to the extent that there is evidence, satisfactory to United HealthCare, that such supplies could not be obtained without cost
   f. Chemotherapy
   g. Dialysis
   h. Speech therapy

Benefits Management Program: Pre-Admission Certification and Prospective Procedure Review

Please read about the Empire Plan Benefits Management Program in the preceding sections of this book.

You must call the Benefits Management Program, if the Empire Plan is primary

If you do not follow the Benefits Management Program requirements for Pre-Admission Certification or Prospective Procedure Review, United HealthCare will review your claim and will apply penalties as explained below.

You must call the Benefits Management Program at 1-800-992-1213 for Pre-Admission Certification before a maternity or scheduled hospital admission and within 48 hours after an emergency or urgent hospital admission.

Pre-Admission Certification: Hospital

If you do not comply with Pre-Admission Certification requirements for hospital admission, you will be subject to paying a $200 hospital deductible and a $100 copayment for each day it is determined that your hospitalization is not medically necessary.

Prospective Procedure Review: MRI

You must call the Benefits Management Program at 1-800-992-1213 for Prospective Procedure Review before having an elective (non-emergency) Magnetic Resonance Imaging (MRI), unless you are having the test as an inpatient in a hospital.

If you fail to call the Benefits Management Program before an elective (non-emergency) MRI and United HealthCare'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 MRI. When United HealthCare receives the claim for the MRI and no call was made, United HealthCare will determine whether the MRI was performed on an emergency basis and whether the MRI was medically necessary.

If you do not call the Benefits Management Program before an MRI and United HealthCare determines that the MRI was performed on a scheduled (non-emergency) basis and that the MRI 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.

When Benefits Management Program requirements apply

The Benefits Management Program requirements apply when the Empire Plan is your primary health insurance coverage. (The Empire Plan is primary when it is responsible for paying for health benefits first, before any other group plan or HMO is liable for payment.)

The Benefits Management Program requirements also apply when you or your enrolled dependents have primary coverage through an HMO with secondary coverage under the Empire Plan, and you choose not to use the HMO.

The Benefits Management Program requirements apply if you live or seek treatment anywhere in the United States, including Alaska and Hawaii.

The Benefits Management Program requirements apply if you will be using your Empire Plan benefits in a medical center or hospital operated by the U. S. Department of Veterans' Affairs.

Home Care Advocacy Program

The Home Care Advocacy Program (HCAP) is the Empire Plan program for home care services, durable medical equipment and certain supplies. HCAP is administered by United HealthCare.

Read this section carefully for details on how to use HCAP. If you do not use HCAP, you will pay higher out-of-pocket costs.

Network coverage: Paid-in-full benefit

You must call 1-800-638-9918 even if Medicare is primary

You must call 1-800-638-9918 to arrange for services and you must use an HCAP-approved provider to receive paid-in-full benefits under Network coverage. You must call HCAP even if Medicare or another plan is primary. If you do not call HCAP before receiving services, you will receive the Non-network level of benefits for medically necessary covered services.

Exception: Call the HCAP network provider directly for authorization before receiving diabetic supplies (except insulin pumps and Medijectors) or ostomy supplies. You may contact the HCAP network providers directly at their toll-free numbers. For most diabetic supplies, call National Diabetic Pharmacies (NDP) at 1-888-306-7337. (For insulin pumps and Medijectors, you must call HCAP for authorization.) For ostomy supplies, call Byram HealthCare Centers at 1-800-354-4054.

The following home care services and/or durable medical equipment or supplies are covered under HCAP when prescribed by your doctor and determined to be medically necessary by United HealthCare.

1. **HCAP-covered Durable Medical Equipment and Supplies**

   To be an HCAP-covered expense, the equipment or supplies must be prescribed by your physician, medically necessary as determined by United HealthCare's HCAP and covered under the Empire Plan.

   In some cases, United HealthCare's HCAP will certify certain durable medical equipment or supplies for an extended period, and you won't have to call each time you need that item.

   Refer to *"Non-network benefits"*, page 79, for coverage of durable medical equipment when you do not use HCAP.

   A. **Durable Medical Equipment** covered under HCAP is medical equipment which is for repeated use and is not a consumable or disposable item, is used primarily for a medical purpose, is appropriate for use in the home, and is generally not useful to a person in the absence of a sickness or injury. When appropriate, HCAP benefits are provided for the rental or purchase of durable medical equipment.

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

      Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement. You will have to call HCAP. HCAP will provide you with the name of an HCAP-approved provider and/or an authorization when necessary.

   B. **Medical Supplies** — Medical supplies covered under HCAP are diabetic supplies, ostomy supplies and supplies that are an integral part of Durable Medical Equipment such as oxygen tubing and oxygen masks.

      Diabetic Supplies — Examples of diabetic supplies include glucometers, test strips, lancets, alcohol swabs and syringes. If you have insulin-dependent diabetes, you are eligible for HCAP benefits for blood testing supplies, including a glucometer. If you have non-insulin-dependent diabetes you may be eligible for blood testing supplies, including a glucometer. To be considered for benefits, you must be managing your diabetes under the direction of a physician, for example through diet, exercise and/or medication.

2. **Skilled Nursing Services in the Home** — You are covered for medically necessary visits by nurses from accredited HCAP participating nursing agencies. Care must be prescribed by, and under the supervision of, a physician. Inpatient visits will not be considered a covered expense.

   The services rendered must be medically necessary and must require the skills of nursing care when that care is needed to manage medical problems of acutely ill patients. This does not include assistance with daily living, companionship or any other service which can be given by a less skilled person, such as a home health aide.

   Refer to *"Non-network benefits"*, page 79, for coverage of nursing services when you do not use HCAP.

   Refer to page 44 of your Empire Blue Cross and Blue Shield Certificate for coverage of a *"Maternity Home Care Visit"* following early discharge after delivery.

3. **Home Infusion Therapy** — You are covered for medically necessary intravenous therapy such as chemotherapy and pain management provided by an HCAP participating agency. Care must be prescribed by and under the supervision of a physician. Prescription medications used in therapies such as chemotherapy and pain management and dispensed by a licensed pharmacy are subject to the provisions of your prescription drug program. (See your *"CIGNA Certificate of Insurance Empire Plan Prescription Drug Program"* beginning on page 122.)
4. **Certain other home health care services and prescription drugs are covered under HCAP only when the home care arranged through HCAP takes the place of hospitalization or care in a skilled nursing facility:**
   A. **Home Health Aides** — Home health aide services consist primarily of caring for the patient in conjunction with skilled nursing services. (The Empire Plan does not cover assistance in activities of daily living, called custodial care.)
   B. **Physical, Occupational and Speech Therapy** - HCAP covers home physical, occupational and speech therapy.
   C. **Prescription Drugs** — Prescription drugs billed by a Home Care Agency certified under Article 36 of the New York State Public Health Law are covered under HCAP if the Empire Plan would have paid for those items if you were in a hospital or confined in a skilled nursing facility. In all other cases, coverage for prescription drugs dispensed by a licensed pharmacy is under and subject to the provisions of your prescription drug program.
   D. **Laboratory Services** — HCAP covers laboratory services provided by or on behalf of the home care agency.

   Coverage ends under HCAP for these services when the home care being provided is no longer taking the place of hospitalization or care in a skilled nursing facility. After HCAP coverage ends, coverage for these services is subject to the provisions of the Participating Provider and Basic Medical Programs. For physical therapy, benefits will be under the Managed Physical Medicine Program.

When do requirements apply?

HCAP requirements apply:

- Whenever you seek Empire Plan coverage for home care services and/or HCAP-covered durable medical equipment or supplies.
- Nationwide. You must call HCAP if you live or seek treatment anywhere in the United States.

After you call

Once you call, HCAP will determine to what extent your home care services and/or durable medical equipment or supplies are medically necessary. You will be advised by telephone what services and supplies are precertified and for how long. For ongoing care, United HealthCare will also send you a letter of confirmation.

Your benefits and responsibilities under HCAP

The following describes your benefits and responsibilities under HCAP.

Network coverage: When you call HCAP and use an HCAP provider

You have a **paid-in-full** benefit under Network coverage when:

1. You call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies; *and*
2. United HealthCare precertifies your home care and/or equipment or supplies as medically necessary; *and*
3. United HealthCare makes or helps you make arrangements with an HCAP-approved provider for covered services and/or equipment or supplies.

When you follow these steps, you will have no claim forms and no out-of-pocket cost, no copayment, no deductible and no exclusion for the first 48 hours of private duty nursing.

Non-network coverage: If you do not call or if you call HCAP but do not use an HCAP provider

You will receive **Non-network** benefits if:

1. You do not call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies; *or*
2. You call HCAP before you receive home care services and/or HCAP-covered durable medical equipment or supplies;

   and United HealthCare precertifies your home care and/or equipment or supplies as medically necessary;

   but you use a non-participating provider that HCAP has not approved for covered services and/or equipment or supplies.

Non-network benefits

If you do not call HCAP for precertification before receiving home care services, durable medical equipment or supplies and/or if you choose to use a non-network provider, you will pay a much higher share of the cost.

48 hour exclusion for nursing care: You are responsible for the cost of the first 48 hours of nursing care per calendar year. This is not a covered expense and will not be applied toward your Basic Medical Program annual deductible.

Basic Medical Program annual deductible applies: You must satisfy your Basic Medical Program annual deductible before non-network benefits will be paid for HCAP covered services, equipment or supplies. The amount applied toward satisfaction of the Basic Medical Program annual deductible for non-network HCAP covered services, equipment and supplies will be the lower of the following:

- the amount you actually paid for a medically necessary service, equipment or supplies covered under HCAP; or
- the network allowance for such service, equipment or supply.

Non-network Benefits: After you have satisfied your Basic Medical Program annual deductible, submit a claim to United HealthCare. You will be reimbursed for medically necessary HCAP covered home care services, durable medical equipment or supplies up to a maximum of 50 percent of the network allowance. You are responsible for any amounts in excess of 50 percent of the network allowance; **the Basic Medical Coinsurance Maximum does not apply.** No expenses you pay in excess of the non-network allowance may be applied to your annual coinsurance maximum for the Basic Medical Program.

Note: Non-network benefits apply to all charges if you don't use HCAP, except that Basic Medical benefits apply to durable medical equipment or supplies that are less than $100 in total and are dispensed by your doctor during an office visit.

Who calls?

If you cannot call HCAP, others may make the call for you: a member of your family or household, your doctor or a member of your doctor's staff, the hospital, the Benefits Management Program Case Manager or the Benefits Management Program discharge unit. But you are responsible for seeing that the call is made.

Call anytime

Call anytime. When your doctor prescribes home care services, durable medical equipment and certain supplies, call HCAP at 1-800-638-9918 before you receive services.

To talk to a coordinator, call Monday through Friday between 8 am and 4:30 pm, Eastern time. HCAP voice mail is available 24 hours a day.

In an emergency or urgent situation, obtain necessary care. Then, you must call HCAP within 48 hours after receiving emergency care or receiving durable medical equipment/supplies. If it is not reasonably possible to call within 48 hours, call HCAP as soon as possible. If HCAP determines that the urgent or emergency care was medically necessary, covered services and/or items will be certified.

Remember, call 1-800-638-9918 before you receive home care services and/or durable medical equipment or supplies. **And call if you have any questions.**

More about HCAP

If you are admitted to the hospital – If you are receiving home care and then are admitted to the hospital, you must call the Benefits Management Program at 1-800-992-1213 before your hospital admission and within 48 hours after an emergency or urgent hospital admission.

Hospice care – HCAP requirements do not apply to hospice care. Refer to *"Hospice Care"* in your Empire Blue Cross and Blue Shield Certificate, page 47, for hospice care coverage.

Medical necessity – If United HealthCare determines that you have received home care services and/or durable medical equipment or supplies that were not medically necessary, you must pay the full cost. When HCAP makes or helps you make the arrangements, you're assured that services and equipment or supplies are medically necessary.

60-day deadline to appeal

HCAP Appeals – All HCAP appeals are handled directly through HCAP. Submit a written appeal within 60 days of denial of benefits or services to United HealthCare, Home Care Advocacy Program, P.O. Box 5400, Kingston, NY 12402-5400 or call HCAP at 1-800-638-9918.

For information on United HealthCare claims appeals, see "How, When and Where to Submit Claims" on pages 89-90.

Managed Physical Medicine Program

The Managed Physical Medicine Program is insured by United HealthCare and administered by Managed Physical Network, Inc. (MPN).

Coverage for chiropractic treatment and physical therapy

Please read this section carefully. You will receive network benefits, the highest level of benefits, when you use MPN network providers for medically necessary chiropractic treatment and physical therapy. You will receive a significantly lower level of benefits when you choose non-network providers.

The Empire Plan Managed Physical Medicine Program covers medically necessary services typically performed by a chiropractor or physical therapist. Other providers, such as osteopaths and occupational therapists, may also provide these services. The provider must be licensed to perform such services in the state where the service is received. Physical therapy must be prescribed by a doctor.

When requirements apply

Managed Physical Medicine Program benefits and responsibilities apply to you and your enrolled dependents whenever you seek coverage for physical therapy or chiropractic treatment, even if you have Medicare or other health insurance coverage as well.

You must follow program requirements if you seek treatment anywhere in the United States, including Alaska and Hawaii.

Refer to your Empire Blue Cross and Blue Shield certificate for coverage of physical therapy in a hospital and in the outpatient department of a hospital following related hospitalization or surgery.

Refer to *"Home Care Advocacy Program"*, beginning on page 76, for coverage of physical therapy at home in lieu of hospitalization or care in a skilled nursing facility.

Network benefits

You pay a $10 copayment for each office visit for chiropractic treatment or physical therapy when you choose an MPN network provider. You pay an additional $10 copayment for related radiology and diagnostic laboratory services billed by the MPN network provider. If an MPN network provider bills for radiology and diagnostic laboratory services performed during a single office visit, only one copayment for those services will apply.

$10 copayments when you use a network provider

You do not need to call MPN before your visit. Your MPN provider will be responsible for certifying the medical necessity of your care. Charges for all certified services will be paid in full except for your copayments. You do not have to pay more than your copayments to a network provider unless you have agreed in writing in advance to pay for non-covered services.

How to find a network provider

You may contact a provider of chiropractic treatment or physical therapy directly and ask if the provider is in the MPN network. Or, you may call 1-800-942-4640. MPN providers are also listed in the Empire Plan Participating Provider Directory on the Internet at http://www.cs.state.ny.us.

Guaranteed access

What if there are no MPN providers in your area? You are guaranteed that network benefits will be available to you under the Managed Physical Medicine Program. Call MPN at 1-800-942-4640. MPN will make arrangements for you to receive medically necessary chiropractic treatment or physical therapy, and you will pay only your $10 copayments for each visit. But, you must call first and you must use the provider with whom MPN has arranged your care.

Non-network benefits

If you receive chiropractic treatment or physical therapy from a non-network provider when MPN has not made arrangements for you, you will pay a much higher share of the cost.

Deductible, coinsurance, annual maximum apply

Deductible applies. For non-network physical medicine office visits, you must meet the Managed Physical Medicine Program annual deductible of $250. Your spouse/domestic partner must meet the $250 annual deductible, and all your enrolled children, combined, must meet the $250 annual deductible. The amount applied toward satisfaction of the deductible will be the amount you actually paid for medically necessary services covered under the Managed Physical Medicine Program or the MPN network allowance for such services, whichever is less. This deductible is separate from other Plan deductibles.

Coinsurance and $1,500 Annual Maximum apply. After you meet your deductible, submit a claim to United HealthCare. You will be reimbursed up to a maximum of 50 percent of the network allowance for medically necessary services, up to a maximum reimbursement of $1,500 per covered person per calendar year.

Your out-of-pocket expenses under the Managed Physical Medicine Program do not count toward your Basic Medical annual deductible and coinsurance maximum or toward your Mental Health and Substance Abuse deductibles.

If MPN determines that the non-network care you received was not medically necessary, you will not receive any Empire Plan benefits, and you will be responsible for the full cost of care.

Other services

Charges by a non-network provider for other medically necessary services such as radiology and diagnostic laboratory tests are covered under the Basic Medical Program, subject to the Basic Medical annual deductible and Basic Medical coinsurance maximum.

Questions?

Call United HealthCare at 1-800-942-4640 and select the Managed Physical Medicine Program from the automated telephone system menu if you have questions about your coverage for chiropractic treatment or physical therapy. To speak with an MPN representative, call during regular business hours, Monday-Friday, 8 am-4:30 pm., Eastern time.

Appeals: 60-day deadline

In order to appeal MPN's determination, submit a written appeal within 60 days to Managed Physical Network, Inc., P.O. Box 8200, Kingston, New York 12402-8200. For information on United HealthCare claims appeal, see *"Appeals"* on pages 92-95.

Infertility Benefits

For the purposes of this benefit, infertility is defined as a condition of an individual who is unable to achieve a pregnancy because the individual and/or partner has been diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but has been unable to carry a fetus to full term.

Infertility benefits, including Qualified Procedures, are subject to the same copayments, deductibles, coinsurance maximums and percentages payable as benefits for other medical conditions under the Participating Provider and Basic Medical programs. Qualified Procedures are subject to a $25,000 lifetime maximum.

By using participating providers, you minimize your out-of-pocket costs. Benefits for Qualified Procedures are not payable if they are not pre-authorized by United HealthCare.

What is covered

Covered Services and Supplies: Patient Education/Program Orientation; Diagnostic Testing; Ovulation Induction/Hormonal Therapy; and Surgery to enhance reproductive capability.

1-800-638-9918 for prior authorization for Qualified Procedures

Certain procedures, called Qualified Procedures, are covered under the Empire Plan only if you call United HealthCare in advance at 1-800-638-9918 and receive prior authorization. Qualified Procedures are specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility. If United HealthCare authorizes benefits, the following Qualified Procedures are covered:

- Artificial insemination
- Assisted Reproductive Technology (ART) procedures including:
  - In vitro fertilization and embryo placement
  - Gamete Intra-Fallopian Transfer (GIFT)
  - Zygote Intra-Fallopian Transfer (ZIFT)
  - Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility
  - Assisted hatching
  - Microsurgical sperm aspiration and extraction procedures, including:
    - Microsurgical Epididymal Sperm Aspiration (MESA), and
    - Testicular Sperm Extraction (TESE)
- Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (that is, freezing and storage of sperm, eggs or embryos) for up to 6 months.

Maximum lifetime benefit

Benefits paid for Qualified Procedures under the Empire Plan are subject to a lifetime maximum of $25,000 per covered individual. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures.

Infertility Centers of Excellence

Centers of Excellence

Infertility Centers of Excellence are a select group of participating providers recognized by United HealthCare as leaders in reproductive medical technology and infertility procedures and contracted by United HealthCare to be Infertility Centers of Excellence. These centers are available to provide to you the listed Covered Services and Supplies and Qualified Procedures. If United HealthCare pre-authorizes infertility treatment at an Infertility Center of Excellence, benefits are payable in full, subject to the maximum lifetime benefit. No copayments will be applied for services provided at the Center of Excellence. Copayments may apply for certain services required by the Center of Excellence and received outside the Center, for example laboratory or pathology tests.

When attending an Infertility Center of Excellence for Qualified Procedures more than 100 miles from a patient's residence, benefits are also available for travel, lodging and meal expenses. Reasonable expenses for the patient and one family member companion traveling on the same day to and/or from the center are payable under this infertility benefit. Travel by private automobile will be reimbursed at the Internal Revenue Service per-mile rate in force at the time. Available coach airfare is covered only when the authorized Infertility Center of Excellence is more than 200 miles from a patient's residence. These benefits are available only if the expenses have been pre-authorized by United HealthCare and are applied toward the $25,000 maximum lifetime benefit.

Infertility: Exclusions and limitations

Charges for the following expenses are **not** covered or payable:

- Experimental infertility procedures. (Infertility procedures performed must be accepted as non-experimental by the American Society of Reproductive Medicine.)
- Fertility drugs prescribed in conjunction with Assisted Reproductive Technology and dispensed by a retail pharmacy are not covered under this benefit. Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under the Empire Plan. (If you have prescription drug coverage through a union Employee Benefit Fund, check with that plan.)
- Medical expenses or other charges related to genetic selection
- Medical expenses or any other charges in connection with surrogacy
- Any donor compensation or fees charged in facilitating a pregnancy
- Any charges for services provided to a donor in facilitating a pregnancy
- Storage of sperm, eggs or embryos for more than 6 months
- Assisted Reproductive Technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant
- Psychological evaluations and counseling. See the GHI/ValueOptions Certificate for coverage that may be provided for psychological evaluations and counseling

Other exclusions and limitations that apply to this benefit are included under Exclusions in the General Provisions section of this Certificate.

United HealthCare General Provisions

Exclusions

Charges for the following services and/or supplies are **not** covered medical expenses:

A. Services or supplies which you received before you were covered under this Plan.

B. Services or supplies which are **not medically necessary** as defined under Meaning of Terms Used in this Certificate.

C. Federal legend drugs and insulin dispensed by a licensed pharmacy.

D. Eyeglasses or contact lenses or exams to prescribe or fit them, except as described in the list of covered medical expenses outlined in the *"Basic Medical Program"* section on page 72.

E. Dental services or supplies provided by a dentist. However, you are covered for dental services and appliances necessary for the correction of damage caused by an accident provided the services are received within 12 months of the accident and while you are covered under this Plan. In addition, you are covered for oral surgery necessary for the correction of damage caused by an illness for which you are eligible for benefits under this Plan and which occurs while you are covered under this Plan. Extractions, dental caries, periodontics (including but not limited to gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered. You are covered for charges incurred for temporomandibular joint syndrome (TMJ) for the following conditions which are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by X-ray: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections, traumatic injuries. For TMJ, covered services include: diagnostic exams, X-rays, models and testing; injections of medications; and trigger point injections.

F. Services or supplies for the administration of anesthesia if the charges for surgery are not covered under this Plan.

G. Services or supplies to the extent they are not covered by Empire Blue Cross and Blue Shield due to non-compliance with the requirements of the Empire Plan for inpatient admission, the mandatory Prospective Procedure Review or for inpatient diagnostic testing.

H. Services deemed Experimental, Investigational or Unproven are not covered under this Plan. However, United HealthCare may deem an Experimental, Investigational or Unproven Service is covered under this Plan for treating a life threatening sickness or condition if:

1. it is determined by United HealthCare that the Experimental, Investigational or Unproven Service at the time of the determination:
   - is proved to be safe with promising efficacy; and
   - is provided in a clinically controlled research setting; and
   - uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health; or
2. Empire Plan benefits have been paid or approved by another Empire Plan carrier for the item or service based on a determination that the service or item is covered under the Empire Plan.
3. Experimental, Investigational or Unproven Services shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. For external appeal provisions, see *"External Appeals"* under Miscellaneous Provisions on page 93. If the External Appeal Agent approves coverage of an Experimental. Investigational or Unproven treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.

I. If routine services are provided by both a nurse midwife and doctor, only one provider will be paid for these services.

J. Services or supplies received because of an occupational injury or an occupational sickness which entitles you to benefits under a workers' compensation or occupational disease law.

K. Services or supplies to the extent they are covered under a mandatory motor vehicle liability law which requires that benefits be provided for personal injury without regard to fault.

L. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Empire Plan were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U. S. Department of Veterans' Affairs for a non-service connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

M. Services or supplies received by you for which no charge would have been made in the absence of coverage under the Empire Plan.

N. Services or supplies for which you are not required to pay.

O. Services or supplies received as a result of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace, which occurs after December 5, 1957.

P. Orthopedic shoes and other supportive devices, and services for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations. However, a medically necessary custom-made orthopedic appliance, commonly known as an orthotic device, used to support, align, prevent or correct deformities or to improve the function of the foot, is covered under the Basic Medical Program.

Q. Services or supplies, including cutting or removal, for treatment of corns, calluses, or toenails, except care which is medically necessary due to metabolic disease diagnosed by a doctor.

R. Services and supplies rendered for convalescent care, custodial care, sanitarium-type care, rest cures, and services or supplies rendered in a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home or in an educational facility except as otherwise specifically covered under this Plan.

S. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance carrier under an individual policy issued to you.

T. Cosmetic or reconstructive surgery or treatment. Surgery or treatment primarily to change appearance is not covered under this Plan. Refer to *"What is covered under the Participating Provider Program"* on page 71 and *"What is covered under the Basic Medical Program"* on page 75 for limited coverage of reconstructive surgery.

U. Services rendered for medical summaries and medical invoice preparations.

V. Services or supplies rendered in conjunction with weight reduction programs, unless the patient is morbidly obese and treatment is in a physician's office. Dietary food supplements or vitamins are not covered medical expenses.

W. Expenses for private duty nursing services while you are an inpatient.

X. Expenses for mental health or substance abuse services and supplies, including alcoholism.

Y. Services furnished on a referral prohibited by the Public Health Law section governing business practices and health services.

Z. Services or supplies which are provided by your father, mother, brother, sister, spouse/domestic partner or children.

Coordination of Benefits

1. **Coordination of Benefits** means that the benefits provided for you under the Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of Coordination of Benefits is to avoid duplicate benefit payments so that the total payment under the Empire Plan and under another plan is not more than the reasonable and customary charge for a service covered under both group plans.
2. Definitions
   - A. **Plan** means a plan which provides benefits or services for or by reason of medical or dental care and which is:
     1. a group insurance plan; or
     2. a blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
     3. a self-insured or non-insured plan; or
     4. any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
     5. a group service plan; or
     6. a group prepayment plan; or
     7. any other plan which covers people as a group; or
     8. a governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
   - B. **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of the Empire Plan which reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts which do not.

3. When coordination of benefits applies and the Empire Plan is secondary, payment under the Empire Plan will be reduced so that the total of all payments or benefits payable under the Empire Plan and under another plan is not more than the reasonable and customary charge for the service you receive.
4. Payments under the Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a Coordination of Benefits or similar provision with the same order of benefit determination as stated in Item 5 and, under that order of benefit determination, the benefits under the Empire Plan are to be determined before the benefits under the other plan.
5. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules which applies:
   A. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
   B. When this Plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are not divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph C below.)
      1. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
      2. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
      3. If the other plan does not have the rule described in subparagraphs (1) and (2) above, but instead has a rule based on gender of the parent and, if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits:
      4. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.
   C. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      1. First, the plan of the parent with custody of the child;
      2. Then, the plan of the spouse of the parent with custody of the child; and
      3. Finally, the plan of the parent not having custody of the child; and
      4. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.
   D. The benefits of a plan which covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule D is ignored.
   E. If none of the rules in A through D above determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

6. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under the Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
7. Any information about covered expenses and benefits which is needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.
8. If an overpayment is made under the Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
9. If payments which should have been made under the Empire Plan have been made under other plans, the party which made the other payments will have the right to receive any amounts which are considered proper under this provision.
10. There is a further condition which applies under the Participating Provider Program. When either Medicare or a plan other than this Plan pays first, and if for any reason the total sum reimbursed by the other plan and this Plan is less than the amount billed the other plan, the participating provider may not charge the balance to you.

Impact of Medicare on this Plan

Definitions

A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.

B. **Primary Payor** means the plan that will determine the medical benefits which will be payable to you first.

C. **Secondary Payor** means a plan that will determine your medical benefits after the primary payor.

D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.

E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in the General Information section of this book.

F. You will be considered **disabled** if you are eligible for Medicare due to your disability.

G. You will be considered to have **end stage renal disease** if you have permanent kidney failure.

Coverage

When you are eligible for primary coverage under Medicare, the benefits under this Plan will change.

*Please refer to the General Information section of this book for information on when you **must** enroll for Medicare and when Medicare becomes your **primary** coverage.* **If you or your dependent is eligible for primary Medicare coverage – even if you or your dependent fails to enroll – your covered medical expenses will be reduced by the amount that could be covered under Medicare, and United HealthCare will consider the balance for payment, subject to copayment, deductible and coinsurance.**

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare+Choice (Risk) Contract, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained in the last paragraph of this section below.

After you have exhausted your 365 benefit days under Medicare and Blue Cross, you may use either your Basic Medical coverage under United HealthCare or your Medicare Reserve Days.

A. **Retired Employees and/or their Dependents** — If you or your dependents are eligible for primary coverage under Medicare – even if you or they fail to enroll – your covered medical expenses will be reduced by the amount that would have been paid

by Medicare, and United HealthCare will consider the balance for payment, subject to copayment, deductible and coinsurance.

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 Schedule of Allowances or Reasonable and Customary Charge as defined in the Meanings of Terms used.

No benefits will be paid for services or supplies provided by a skilled nursing facility.

B. **Active Employees and/or their Dependents** — This Plan will automatically be the primary payor for active enrolled employees, regardless of age, and for the employee's enrolled dependents (except for a domestic partner eligible for Medicare due to age) unless end stage renal disease provisions apply. Medicare will be the secondary payor. As the primary payor, United HealthCare will pay benefits for covered medical expenses under this Plan; as secondary payor, Medicare's benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

   The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

   Note for Domestic Partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

C. **Disability** — Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.

D. **End Stage Renal Disease** — For those eligible for Medicare due to end stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first 30 months of treatment, then Medicare becomes primary. See *"Medicare end stage renal disease coordination"* on page 27 of the General Information section. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

E. **Veterans' Facilities.** Where services are provided in a U.S. Department of Veterans' Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a non-governmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan's benefits. The Medicare amount payable is the amount that would be payable to a Medicare eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a non-governmental facility.

Medicare+Choice (formerly Medicare Risk HMOs)

For Medicare-primary Empire Plan enrollees who also enroll in a Health Maintenance Organization under a Medicare Risk Contract. If you or your dependent enrolls in a Health Maintenance Organization under a Medicare+Choice Contract, the Empire Plan will not provide benefits for any services available through your HMO or services that would have been covered by your HMO if you had complied with the HMO's requirements for coverage. Covered medical expenses under the Empire Plan are limited to expenses not covered under your Medicare+Choice Contract with the HMO. If your HMO Medicare+Choice Contract has a Point-of-Service option that provides partial coverage for services you receive outside the HMO, covered medical expenses under the Empire Plan are limited to the difference between the HMO's payment and the amount of covered expenses under the Empire Plan.

How, When and Where to Submit Claims

How

1. If you go to a participating provider or MPN Network provider, all you have to do is ensure that the provider has accurate and up-to-date personal information—name, address, identification number, signature—needed to complete the claim form. Your participating provider, MPN Network provider or HCAP-approved provider fills out the form and sends it directly to United HealthCare. The claim forms are in each provider's office.
2. If you use a non-participating provider or a provider who is not in the MPN Network, or is not HCAP-approved, claims may be submitted at any time after the appropriate annual deductible has been satisfied but not later than 90 days after the end of the calendar year in which covered medical expenses were incurred, or 90 days after Medicare or another plan processes your claim. However, you may submit claims later if it was not reasonably possible for you to meet this deadline (for example, due to your illness); you must provide documentation.

   You may obtain a claim form from your agency Health Benefits Administrator or from:

   United HealthCare
   P.O. Box 1600
   Kingston, New York 12402-1600
   1-800-942-4640

   Have the doctor or other provider fill in all the information asked for on the claim form and sign it. If the form is not filled out by the provider and bills are submitted, they must include all the information asked for on the claim form. Missing information will delay processing.

   If Empire Blue Cross and Blue Shield paid part of the costs, the "Statement of Payment" sent to you by Empire Blue Cross and Blue Shield must be enclosed with the claim.

   If Medicare is primary, a "Medicare Summary Notice" (or "Explanation of Medicare Benefits") **must be submitted with the completed claim form or detailed bills** for all items to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the Medicare Summary Notice and other documents for your records.

Remember - If Medicare provides primary coverage, your provider must submit bills to Medicare first.

When

1. If you use a participating provider, MPN Network provider or HCAP Network provider, your provider will submit a claim to United HealthCare.
2. If you use a non-participating provider or a provider who is not in the MPN Network, or is not HCAP-approved, claims may be submitted at any time after the appropriate annual deductible has been satisfied but not later than 90 days after the end of the calendar year in which covered medical expenses were incurred, or 90 days after Medicare or another plan processes your claim. However, you may submit claims later if it was not reasonably possible for you to meet this deadline (for example, due to your illness); you must provide documentation.

Where

Completed claim forms with supporting bills, receipts, "Statement of Payment" from Empire Blue Cross and Blue Shield and Medicare Summary Notice should be sent to:

United HealthCare
P.O. Box 1600
Kingston, New York 12402-1600

Fraud

Any person who intentionally defrauds an insurance company by filing a claim which contains false or misleading information or conceals information which is necessary to properly evaluate a claim has committed a crime.

Verification of claim information

United HealthCare has the right to request from hospitals, doctors or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

Claim inquiries

When you have a question about your claim, you may call the following toll-free number at United HealthCare: 1-800-942-4640. TTY (Teletypewriter) line for enrollees who use a TTY because of a hearing or speech disability: 1-888-697-9054.

If you do not speak English or are hearing-impaired or speech-impaired you can receive assistance. Contact Customer Service in Kingston, New York at 1-800-942-4640. They can direct you on how to get further help through a language translation line or TTY (Text Telephone).

Claim determinations

Claim determinations will be made within 30 days after receipt of the necessary information.

Denial of claim

If United HealthCare denies your claim for benefits for a medical procedure or service on the basis that the medical procedure or service is not medically necessary, benefits in accordance with Empire Plan provisions will be paid under the Participating Provider or Basic Medical Program for covered expenses if:

- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service provided to you and has paid benefits in accordance with Empire Plan provisions on your behalf for that medical procedure or service; or
- Another Empire Plan carrier has liability for some portion of the expense for that same medical procedure or service proposed for you and has provided to you a written pre-authorization of benefits stating that Empire Plan benefits will be available to you for that medical procedure or service and the procedure or service confirms the documentation submitted for the pre-authorization; and
- You provide to United HealthCare proof of payment or pre-authorization of benefits from the other Empire Plan carrier regarding the availability of Empire Plan benefits to you for that medical procedure or service.

In addition, the above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

Right to Convert to an Individual Policy

Right to convert

After you have been covered under this Plan as an enrollee for at least three months and your coverage ends because:

1. your employment ends,
2. you are no longer in a class that remains eligible for coverage under this Plan,
3. COBRA continuation period ends, or
4. this Plan ends, you may have the right to convert to an individual policy, issued by United HealthCare, providing hospital, surgical and medical coverage for you and your dependents.

If your coverage under this Plan ends for any cause stated above, the proper form with which to apply for conversion will be sent to you.

When applying for a conversion policy, proof that you are insurable is not required by United HealthCare.

Deadlines apply

Your application for conversion to an individual policy and the first premium must be submitted to United HealthCare within:

1. 45 days from the date your coverage ends, if written notice of the right to convert is given to you within 15 days after that date;
2. 45 days from the date you receive written notice of the right to convert, if that notice is given more than 15 days but less than 90 days after your coverage ends; or
3. 90 days from the date your coverage ends, if no written notice of the right to convert is given.

United HealthCare will not issue a conversion policy if coverage ends because you fail to remit the required cost for coverage continuation under COBRA; or if, on the date your coverage ends, you are eligible for similar types of benefits under any other group plan or program and those benefits, together with the converted policy would, according to United HealthCare's standards, result in more insurance than is needed or in duplicate benefits; nor will such a policy be issued if you are eligible for Medicare due to age or if your coverage ends because you fail to make a required payment to its cost. If you are under age 65 and eligible for Medicare due to disability, you are eligible for a direct-pay policy unless you have coverage which would duplicate the conversion coverage.

Your dependents may apply for an individual policy under the same conditions if they do so within 45 days after coverage ends because COBRA coverage ends, or because of your death or because they no longer qualify as dependents.

Your dependents should request the proper conversion form by writing to:

United HealthCare
P.O. Box 1600
Kingston, New York 12402-1600

Please refer to the General Information section of this book for details on how you may continue coverage under COBRA after termination.

Miscellaneous Provisions

Confined on effective date of coverage

If you become covered under this Plan and on that date are confined in a hospital or similar facility for care or treatment or are confined at home under the care of a doctor for a sickness, injury or pregnancy, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

Benefits after termination of coverage

If you are totally disabled on the date coverage ends on your account, United HealthCare will pay benefits for covered medical expenses for that total disability, on the same basis as if coverage had continued without change, until the day you are no longer totally disabled or 90 days after the day your coverage ended, whichever is earlier. Call United HealthCare at 1-800-942-4640 if you need more information about benefits after termination of coverage.

Total Disability and **Totally Disabled** mean that because of a sickness or injury you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

Confined on date of change of options

Option means your choice of either the Empire Plan or a Health Maintenance Organization (HMO).

If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or similar facility or confined at home under the care of a doctor:

a. if the transfer is out of the Empire Plan, and you are confined on the day coverage ends, benefits are payable as set forth above under **Benefits After Termination of Coverage;** and

b. if the transfer is into the Empire Plan, benefits are payable to the extent they exceed or are not paid through your former HMO.

Termination of coverage

1. Coverage will end when you are no longer eligible to participate in this Plan. *Refer to the "General Information" section of this book.*
2. If this Plan ends, your coverage will end.
3. Coverage on account of a dependent will end on the date that dependent ceases to be a dependent as defined in the General Information book.
4. If a payment which is required by the State of New York to the cost of coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim which is incurred before your coverage ends, for any reason, will not be affected; also see **Benefits After Termination of Coverage.**

Refund to United HealthCare for overpayment of benefits

If United HealthCare pays benefits under this Plan for covered medical expenses incurred on your account, and it is found that United HealthCare paid *more* benefits than should have been paid because all or some of those expenses were not paid by you, or you were repaid for all or some of those expenses by another source, United HealthCare will have the right to a refund from you.

The amount of the refund is the difference between the amount of benefits paid by United HealthCare for those expenses and the amount of benefits which should have been paid by United HealthCare for those expenses. If a refund is not made, United HealthCare may offset future benefits by the amount of overpayment.

If benefits were paid by United HealthCare for expenses *not covered* by this Plan, United HealthCare will have the right to a refund from you. If a refund is not made, United HealthCare may offset future benefits by the amount of overpayment.

Time limits on starting lawsuits

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive written notice that benefits have been denied.

Inquiries

If you have any questions regarding your claim or the availability of benefits under this Plan, you should call United HealthCare. Customer Service Representatives are available to speak with you Monday through Friday between 8 am and 4:30 pm Eastern Time.

Appeals

You or another person acting on your behalf may submit an appeal. If a claim for benefits payment or a request for precertification is denied in whole or in part, two levels of appeal are available to you. You may submit an appeal by writing to:

United HealthCare
P.O. Box 1600
Kingston, New York 12402-1600

or

by calling the toll free number for Customer Service in Kingston, New York at:

1-800-942-4640.

Level 1: 60-day deadline

Level 1 Appeals: A request for review must be directed to United HealthCare within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, you should state the reason why you believe the claim determination or precertification improperly reduced or denied your benefits. Also, submit any data or comments to support the appeal of the original determination as well as any data or information requested by United HealthCare. A written acknowledgment of your appeal will be sent to you within 15 days after it is received.

For a benefit payment appeal, a review of the appeal will be done, and within 60 days of your request United HealthCare will provide you with a written response. If the claim review process cannot be completed within 60 days, United HealthCare will notify you of the delay within the 60-day period and will provide a written response to the request for claim review within 60 days after receipt of all information necessary to complete the review.

For a precertification appeal, a review of the appeal will be done, and within 30 days of your request United HealthCare will provide you with a written response. If the precertification review process cannot be completed within 30 days, United HealthCare will notify you of the delay within 15 days and will provide a written response to the request for precertification review within 30 days after receipt of all information necessary to complete the review.

If an appeal involves a clinical matter, a Medical Director will be responsible for ensuring the appeal is reviewed by an appropriate Provider who did not previously review the claim or precertification request.

If an appeal involves an administrative matter, it will be reviewed by an employee of United HealthCare with problem-solving authority above that of the original reviewer.

If the determination is upheld, United HealthCare's written response will cite the specific Plan provision(s) upon which the denial is based and will include both of the following:

- Detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.
- Notification of your right to a further review.

Level 2: 60-day deadline

Level 2 Appeals: If, as a result of the Level 1 review, the original determination of benefits is upheld by United HealthCare, in whole or in part, you can request a Level 2 review. This request should be directed either in writing or by telephone to United HealthCare within 60 days after you receive notice of the Level 1 appeal determination. When requesting the Level 2 review, you should state the reasons you believe the benefit reduction or denial was improperly upheld and include any information requested by United HealthCare along with any additional data, questions, or comments deemed appropriate. You will receive a written notice stating the results of the Level 2 review by United HealthCare within 30 business days from the date all necessary information is received.

If an appeal involves a clinical matter, a Medical Director will be responsible for ensuring the appeal is reviewed by an appropriate Provider who did not previously review the claim or precertification request.

If an appeal involves an administrative matter, it will be reviewed by an employee of United HealthCare with problem-solving authority above that of the previous reviewer.

If the determination is upheld, United HealthCare's written response will cite the specific Plan provision(s) upon which the denial is based and will provide detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.

Appeals Involving Urgent Situations: If an appeal involves a situation in which your Provider believes a delay would significantly increase the risk to your health or if you are in the middle of a course of treatment, the appeal will be resolved in no more than two business days from receipt of all necessary information. Notice of the determination will be made directly to the person filing the appeal (you or the person acting on your behalf). Written notice of the determination will be sent within 24 hours following the determination.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, Agency Building One, Empire State Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9 am - 5 pm.

External Appeals

Your right to an External Appeal Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if United HealthCare has denied coverage on the basis that the service is not medically necessary or is an experimental

or investigational treatment, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary If you have been denied coverage on the basis that the service is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and if any new or additional information regarding the service or procedure was presented for consideration, United HealthCare must have upheld the denial; or you and United HealthCare must agree in writing to waive any internal appeal.

Your right to appeal a determination that a service is experimental or investigational If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

A. The service must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and if any new or additional information regarding the service or procedure was presented for consideration, United HealthCare must have upheld the denial; or you and United HealthCare must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation - your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable); or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal process: If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and United HealthCare have agreed in writing to waive any

internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. United HealthCare will provide an external appeal application with the final adverse determination issued through United HealthCare's internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which United HealthCare based its denial, the External Appeal Agent will share this information with United HealthCare in order for it to exercise its right to reconsider its decision. If United HealthCare chooses to exercise this right, United HealthCare will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), United HealthCare does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or United HealthCare. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and United HealthCare by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision. If the External Appeal Agent overturns United HealthCare's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, United HealthCare will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, United HealthCare will only cover the costs of services required to provide treatment to you according to the design of the trial. United HealthCare shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and United HealthCare. The External Appeal Agent's decision is admissible in any court proceeding.

United HealthCare will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. United HealthCare will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an External Appeal

It is YOUR RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

45-day deadline

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from United HealthCare that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. United HealthCare has no authority to grant an extension of this deadline.

Certificate of Insurance
Group Health Incorporated

(Herein referred to as GHI)
441 Ninth Avenue
New York, New York 10001

GHI certifies that under and subject to the terms and conditions of Group Policy PLH-5243 issued to

State of New York

(Herein called the State)

each eligible Enrollee shall become insured on the Enrollee's own account and on account of each of the Enrollee's eligible Dependents for the coverage described in this Certificate, on the later of:

(a) January 1, 2001, or

(b) the date determined in accordance with the Regulations of the President of the Civil Service Commission.

The benefits under this Program do not at any time provide paid-up insurance, or loan or cash values.

No agent has the authority:

(a) to accept or to waive any required notice or proof of a claim; nor

(b) to extend the time within which any such notice or proof must be given to GHI.

This Certificate may not be assigned by the Enrollee. An Enrollee's benefits may not be assigned prior to a loss.

The insurance evidenced by this Certificate does NOT provide basic hospital insurance, basic medical insurance or major medical insurance as defined by the New York State Insurance Department.

Group Health Incorporated

Form No. PLH-5244

Group Health Incorporated

Certificate of Insurance

Section IV:
GHI CERTIFICATE OF INSURANCE

Mental Health and Substance Abuse Program

Overview

The Empire Plan Mental Health and Substance Abuse Program provides comprehensive coverage for mental health and substance abuse care, including alcoholism. GHI is the Program insurer and ValueOptions is the administrator of the Program.

Review the benefits and exclusions in this Certificate before you obtain services. Excluded services and conditions will not be covered under the Program. If your inpatient or outpatient treatment is found not medically necessary, you will not receive any Empire Plan benefits, and you will be responsible for the full cost of care.

Coverage

Covered services for mental health and substance abuse care, including care for alcoholism, include:

- emergency assessments at all times;
- inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge;
- alternatives to inpatient care (such as certified residential treatment facilities and certified halfway houses, etc.);
- outpatient mental health services;
- inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment;
- substance abuse structured outpatient rehabilitation and aftercare;
- electro-convulsive therapy;
- medication management;
- ambulance services; and
- psychiatric second opinions.

You must call ValueOptions at 1-800-446-3995

Before you seek mental health or substance abuse care, including treatment for alcoholism, you must call ValueOptions at 1-800-446-3995. You must call within 48 hours after an emergency mental health or substance abuse hospitalization.

If you do not call, or if you call but do not follow ValueOptions' recommendations, you will receive a significantly lower level of benefits.

Calling ValueOptions is the first step in ensuring that you will be eligible to receive the highest level of benefits. ValueOptions is always open, 24 hours a day, every day of the year.

The Empire Plan Mental Health and Substance Abuse Program has two levels of benefits for covered services: network coverage and non-network coverage.

Highest level of benefits when you call and follow ValueOptions' recommendations

You qualify for network coverage when:

- You call ValueOptions before your treatment begins, and
- You are treated by a provider ValueOptions recommends.

Usually, you will be referred to a network provider or facility. However, you will still qualify for network coverage if ValueOptions refers you to a non-network provider or facility.

Lower benefits when you don't call ValueOptions, you don't use a recommended provider

There are limited benefits available for medically necessary care when you don't use ValueOptions. These benefits are substantially lower than those available when you call ValueOptions and seek care from a recommended provider.

You will receive non-network coverage for covered services when:

- You do not call ValueOptions, and/or
- You call ValueOptions but do not follow their recommendations.

The mental health and substance abuse care you obtain will be covered by GHI only if it meets the conditions for coverage stated in this Certificate. Read this entire Certificate in order to understand the Program.

Program benefits and responsibilities apply to you and your enrolled dependents whenever you seek Empire Plan coverage for these services, even if you have Medicare or other health insurance coverage, as well.

Key terms are used throughout the Certificate. Read the section of the Certificate called *"Meaning of Key Terms"* for definition of these terms.

If you have questions about the Empire Plan Mental Health and Substance Abuse Program, call ValueOptions at 1-800-446-3995. TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-334-1897.

Meaning of Key Terms

Here are definitions of the key terms used throughout this Certificate. In order to understand them fully, read the entire Certificate to see how these terms are used in the context of the coverage provided to you.

1. **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. In all cases, the facility must also be approved by ValueOptions.

   Under network coverage, residential treatment centers, halfway houses, group homes, partial hospitalization programs and continuing day treatment programs will be considered approved facilities, if they satisfy the requirements above and admission is certified by ValueOptions.
2. **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.
3. **Certification or Certified** means a determination by ValueOptions that mental health care or substance abuse care or proposed care is a medically necessary, covered service in accordance with the terms of this Certificate.
4. **Clinical Referral Line** means the clinical resource and referral service which you must call prior to receiving any covered services. You may call 24 hours a day, every day of the year, through a toll-free number, 1-800-446-3995.
5. **Concurrent Review** means ValueOptions' utilization review and medical management program under which ValueOptions reviews the medical necessity of mental health care and substance abuse services. ValueOptions' review is conducted by a team of licensed psychiatric nurses, social workers, board-certified or board-eligible psychiatrists and clinical psychologists, to determine whether proposed services are medically necessary for your diagnosed condition(s). This program includes combined outpatient and inpatient review as described in this Certificate.
6. **Copayment** means the amount you are required to pay for covered services you obtain from a network provider for outpatient services under the Mental Health and Substance Abuse Program. Please refer to the *"Schedule of Benefits for Covered Services"* on page 108 for the exact amount of copayment. Copayment applies only to network coverage.
7. **Course of Treatment** means the period of time, as determined by ValueOptions, required to provide mental health and substance abuse care to you for the resolution or stabilization of specific symptoms or a particular disorder. A course of treatment may involve multiple providers.

8. **Covered Services** means medically necessary mental health and substance abuse care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.
9. **Covered Expenses** means:
    a. under the network portion of the Program, the network allowance for any medically necessary covered services provided to you under the Program by a network provider.
    b. under the non-network portion of the Program, the non-network allowance for medically necessary covered services provided to you under the Program by a non-network provider. No more than the non-network allowance will be considered by the Program for medically necessary covered services.

    A covered expense is incurred on the date you receive the service.

    A more detailed description of covered expenses and exclusions follows.
10. **Crisis Intervention Visits** means visits for treatment of an acute emotional disturbance which results in a temporary inability to function in one's daily life.

    Examples of situations meeting this definition include: (a) an acute psychotic reaction, (b) loss of coping capacity, and (c) any situation endangering the patient, others or property.

    Such crisis is usually precipitated by an adverse event such as: (a) loss of crucial person through death, divorce or separation, (b) serious illness, accident or sudden heart attack, (c) onset of disabling psychiatric symptoms, or (d) a social trauma such as rape or robbery.
11. **Deductible** means the amount you must pay each calendar year for covered services under the non-network portion of the Mental Health and Substance Abuse Program before payment will be made to you. There are separate deductibles for inpatient and outpatient services. These deductibles cannot be combined.

    The amount applied toward satisfaction of the deductible will be the lower of the following:
    a. the amount you actually paid for a medically necessary service or supply covered under the non-network portion of the Program; or
    b. the network allowance for such service or supply.

    The deductible applies only to the non-network coverage.

    The Mental Health and Substance Abuse Program deductibles are separate from the Basic Medical and Managed Physical Medicine Program annual deductibles. The mental health and substance abuse deductibles cannot be combined with any other deductible or out-of-pocket provision.
12. **Emergency** Care is care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
    1. placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy;
    2. serious impairment to such person's bodily functions;
    3. serious dysfunction of any bodily organ or part of such person; or
    4. serious disfigurement of such person.
13. **GHI** means Group Health Incorporated, which is the insurer for the Empire Plan Mental Health and Substance Abuse Program.
14. **Inpatient Services** means those services rendered in an approved facility to a patient who has been admitted for an overnight stay and is charged for room and board.

15. **Medically Necessary** means a service which ValueOptions has certified to be: (a) medically required; (b) having a strong likelihood of improving your condition; and (c) provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted psychiatric and mental health practices and the professional and technical standards adopted by ValueOptions.

    Although a practitioner may recommend that a covered person receive a service or be confined to an approved facility, that recommendation does not mean:

    a. that such service or confinement will be deemed to be medically necessary; or

    b. that benefits will be paid under this Program for such service or confinement.

16. **Mental Health Care** means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of ValueOptions, is directed predominately at treatable behavioral manifestations of a condition that ValueOptions determines: (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

17. **Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you under the network provider portion of the Program.

18. **Network Coverage** means the higher level of benefits provided by the Program when you receive medically necessary services from a provider recommended to you by ValueOptions.

19. **Network Facility** means an approved facility that has entered into a network provider agreement as an independent contractor with ValueOptions. The records of ValueOptions shall be conclusive as to whether an institution has a network provider agreement in effect on the date that you obtain services. A non-network facility can be considered a network facility on a case-by-case basis when approved by ValueOptions.

20. **Network Practitioner** means a practitioner who has entered into an agreement with ValueOptions as an independent contractor to provide covered services to you. The records of ValueOptions shall be conclusive as to whether a person had a network provider agreement in effect on the date that you obtained services. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by ValueOptions.

21. **Network Provider** means either a network practitioner or a network facility.

22. **Non-network Allowance** means the lower of the following:

    a. The amount you actually paid for a service or supply covered under the non-network portion of the Program; or

    b. **For a Facility:** 50 percent of the average network allowance of all ValueOptions network facilities in the county where you receive care. If there are no network facilities in the county where you receive care, or if you receive care outside New York State, the non-network allowance will be 50 percent of the average ValueOptions network allowance for New York State. County-specific and statewide-average network allowances will be computed by ValueOptions annually.

       For a Practitioner: 50 percent of the network allowance for the service you receive.

    The non-network allowance for a service or supply is determined by ValueOptions according to established guidelines. The non-network allowance is used as a basis for determining the amount of Program benefits you are entitled to receive for any service or supply you obtain under the non-network portion of the Program. Please read the Schedule of Benefits for Covered Services section of this Certificate for a full explanation of how the amount of non-network coverage is determined.

23. **Non-network Coverage** means the lower level of reimbursement paid by the Program when you receive medically necessary covered services from a non-network

provider and you comply with the Program requirements outlined in this Certificate. If you do not call or you do not follow ValueOptions' recommendations, you will receive non-network coverage.

24. **Non-network Provider** means a practitioner or approved facility which has not entered into an agreement with ValueOptions to provide covered services to you.
25. **Outpatient Services** means those services rendered in a practitioner's office or in the department of an approved facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.
26. **Partial Hospitalization** (day or night care center) means a stay in a center maintained by an approved facility that has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program. A patient must remain in a partial hospitalization program for at least three continuous hours, receiving care that is provided in lieu of inpatient mental health hospitalization.
27. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who maintains an active clinical practice and who renders medical necessity decisions on questionable cases.
28. **Practitioner** means:
    a. a physician; or
    b. a psychologist; or
    c. a licensed and registered social worker with at least six years of post-degree experience who is qualified by the New York State Board for Social Work. In New York State, this is determined by the "R" number given to qualified social workers. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or
    d. a Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist.
    e. a Registered Nurse Practitioner: a nurse with a Master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided; must be certified and have a practice agreement in effect with a network physician.

    Each of the above must be licensed to provide covered services in the state where such practitioner's services are provided and meet the credentialing requirements of ValueOptions.
29. **Program** means the Empire Plan Mental Health and Substance Abuse Program. This Program provides coverage under Group Policy No. PLH-5243 issued to the State of New York, the policyholder, by GHI. This Program replaces coverage for mental health and substance abuse care, under Group Policy No. 34450-G issued to the State of New York by Metropolitan Life Insurance Company.
30. **Provider** means a practitioner or approved facility that supplies you with covered services under the Mental Health and Substance Abuse Program. The fact that a practitioner or approved facility claims to supply you with mental health or substance abuse services has no bearing on whether that practitioner or approved facility is a provider covered under the Program.

    A service or supply which can lawfully be provided only by a licensed practitioner or approved facility will be covered by this Program only if such practitioner or approved facility is in fact properly licensed and is permitted, under the terms of that license, to do so at the time you receive a covered service or supply. A person or facility that is not properly licensed cannot be a covered provider under the Program. The records of any agency authorized to license persons or facilities who supply covered services shall be conclusive as to whether that person or facility was properly licensed at the time you receive any service or supply.

31. **Referral** means the process by which ValueOptions' 24-hour, toll-free Clinical Referral Line refers you to a provider to obtain covered mental health and substance abuse care.
32. **Structured Outpatient Rehabilitation Program** means a program that provides substance abuse care and is an operational component of an approved facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an approved facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents.

    The program must also meet all applicable federal, state and local laws and regulations.

    A Structured Outpatient Rehabilitation Program is a program in which the patient participates, on an outpatient basis, in prescribed formalized treatment, which includes an intensive phase involving more than once-weekly treatment, as well as an aftercare component, which includes weekly follow-up/support visits. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.
33. **Substance Abuse Care** means medically necessary care provided by an eligible provider for the illness or condition that ValueOptions has determined: (a) is a clinically significant behavioral or psychological syndrome or pattern; (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) is a condition which has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this Program.
34. **ValueOptions** is the company selected by the State of New York to administer the Empire Plan Mental Health and Substance Abuse Program. ValueOptions provides services for GHI in the administration of this Program.
35. **You/Your** means any Empire Plan enrollee covered by this Program and any dependent member of an enrollee's family who is also covered. Enrollee and dependent are defined in your NYSHIP General Information Book. Where this Certificate refers to "you" making the call to obtain network coverage, "you"/"your" can also mean a member of your family or household.

How to Receive Benefits for Mental Health and Substance Abuse Care

You must call

Before you seek treatment for mental health or substance abuse, including alcoholism, you must call ValueOptions at 1-800-446-3995.

You must call ValueOptions even when a doctor refers you to a mental health professional or facility. You may ask ValueOptions to refer you to a particular provider. However, ValueOptions will determine the appropriateness of this referral.

The advantages of making this call are:

- You will receive help in choosing the right provider. You don't have to guess which professional can help you.
- You will have access to an extensive network of quality providers in your area, carefully chosen for their training and experience.
- You will reduce out-of-pocket expenses and you can get the recommended care without worrying about the bill. Except for any copayments, the bill is paid when you follow ValueOptions' recommendation, and there are no claim forms.
- When you use ValueOptions for intervention following a significant life crisis, you are eligible for up to three outpatient visits without a copayment.
- You will receive confidential help - no one needs to know you are making the call.

The ValueOptions network and the referral process

The Mental Health and Substance Abuse Program has two levels of benefits: network coverage and non-network coverage. By following the Program requirements for network coverage, you will receive the highest level of benefits. Please refer to the Schedule of Benefits for Covered Services for a complete description of the two benefit levels.

ValueOptions' network gives you access to a wide range of providers when you need mental health or substance abuse care. These providers are in your community and many of them have been caring for Empire Plan enrollees and their families for years.

Program requirements apply nationwide

You must follow the requirements for the Mental Health and Substance Abuse Program whenever you will be seeking Empire Plan coverage for these services. You must follow Program requirements even if Medicare or another health insurance plan is your primary coverage. Program requirements apply nationwide regardless of where you seek mental health and substance abuse services.

Program requirements for network coverage

In order to receive network coverage, the highest level of benefits:

- You must call ValueOptions before outpatient treatment begins. You must call ValueOptions before you are admitted as an inpatient. (Requirements are different for an emergency. See the section below on Emergency Services.) **and**
- You must be treated by a provider or admitted to a facility recommended to you by ValueOptions.

When you follow these requirements for network coverage, the network provider will be responsible for obtaining certification from ValueOptions. Both you and your provider will receive written confirmation from ValueOptions indicating the care (number of visits or length of stay) which has been certified.

Lower benefits apply if you don't call ValueOptions or if you don't use a recommended provider

Limited benefits are available for medically necessary care when you do not follow the Program requirements for network coverage. These benefits are substantially lower than those available when you call ValueOptions and seek care from a recommended provider. See the Schedule of Benefits for Covered Services for a description of non-network coverage.

Before you choose a non-network provider, consider the high cost of treatment.

Program requirements if you choose to use a non-network provider

For inpatient admission to a non-network facility, you must call ValueOptions before the admission to have the medical necessity of the admission certified.

If you choose a non-network provider for outpatient treatment, call ValueOptions early in your treatment so that ValueOptions can begin the process of determining whether your treatment will be covered. You must call before the sixth visit to begin the certification process. ValueOptions must certify any outpatient visits beyond the tenth such visit during any course of treatment.

When you use a non-network provider, you are responsible for obtaining certification from ValueOptions. You will receive written confirmation from ValueOptions indicating the care (number of visits or length of stay) which has been certified.

Emergency services

In an emergency, ValueOptions will either arrange for an appropriate provider to call you back right away (usually within 30 minutes), or direct you to an appropriate facility for treatment. In a life threatening emergency situation, you should go or be taken to the nearest hospital emergency room for treatment. You must then contact ValueOptions for certification of emergency services within 48 hours.

Only emergency services certified by ValueOptions will be considered covered services at the network coverage level. When you receive medically necessary covered services from a non-network provider in a certified emergency, the Program will provide network coverage until you can be transferred to a network facility.

You will receive non-network coverage for covered outpatient services if you do not call ValueOptions for certification when you receive medically necessary emergency care at a hospital and are not admitted as an inpatient following that care.

Call ValueOptions at 1-800-446-3995

You or a member of your family or household may place the call. In the case of an emergency or urgent situation, your doctor, a member of your doctor's staff, or the hospital admitting office, may place the call for you. Where this Certificate refers to "you" making the call, keep in mind that other people listed may also call. **But it is your responsibility to see that the call is made.**

Clinical Referral Line

You must call ValueOptions' Clinical Referral Line at 1-800-446-3995 for referrals to providers. Whenever you or your family faces a mental health or substance abuse problem, including alcoholism, getting help begins with a call to ValueOptions. By making the call before you receive services, and then obtaining care from a provider referred to you by ValueOptions, you will qualify for network coverage. Usually, ValueOptions will refer you to a network practitioner or network facility. However, you will also qualify for network coverage if no network provider is available and ValueOptions refers you to a non-network provider.

The Clinical Referral Line is available 24 hours a day, every day of the year. It is staffed by clinicians who have an average of seven years of professional experience in the mental health and substance abuse field. These highly trained and experienced clinicians are available to help you determine the most appropriate course of action.

Call when you use a non-network provider

To be certain that your care is medically necessary when you choose to use a non-network provider, you must call ValueOptions to start the certification process. Call ValueOptions at 1-800-446-3995 between 8 am and 5 pm on business days and select the Customer Services Line. Ask ValueOptions to mail an Outpatient Treatment Report to your non-network provider. If you do not call when you use a non-network provider, and your inpatient or outpatient treatment is not found to be medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

Show your identification card

You must show your identification card every time you request covered services from network providers. Possession and use of an identification card is not entitlement to benefits. Coverage for benefits is subject to verification of eligibility for the date covered services are rendered, and all the terms, conditions, limitations and exclusions set out in this Certificate.

Release of medical records

As a condition of receiving benefits under this Program, you authorize any provider who has provided services to you to provide ValueOptions and GHI with all information and records relating to such services. At all times, ValueOptions and GHI will treat medical records and information in strictest confidence.

Concurrent Review

ValueOptions reviews treatment

After the initial certification, ValueOptions monitors your care throughout your course of treatment to make sure it remains consistent with your medical needs. The Concurrent Review is based on the following criteria and applies whether you choose a network or non-network provider:

- medical necessity of treatment to date,
- diagnosis,
- severity of illness,
- proposed level of care, and
- alternative treatment approaches.

ValueOptions must continue to certify the medical necessity of your care for your Empire Plan benefits to continue.

If ValueOptions determines that inpatient treatment is no longer necessary, ValueOptions will notify you, your doctor and the facility no later than the day before the day on which inpatient benefits cease. ValueOptions will assist you in making the transition from inpatient care to the appropriate level of treatment with a network provider.

Certification denial and appeal process: deadlines apply

Only a ValueOptions peer advisor can deny certification. If certification for any covered service is denied, ValueOptions will notify you and the applicable provider of the denial and provide information on how to request an appeal of such decision by telephone. You will have 60 days to request an appeal.

When you or your practitioner requests an appeal of ValueOptions' decision to deny certification, another ValueOptions peer advisor will review your case and make a determination. The determination will be made as soon as your practitioner provides all pertinent information to the ValueOptions peer advisor in a telephone review. You and your practitioner will be advised in writing of ValueOptions' decision.

If the peer advisor's determination is to continue to deny certification, you and your provider will be provided with written information on how to request a second level appeal of ValueOptions' decision. You have 30 days from the date of your receipt of ValueOptions' written denial notice to request a second level appeal.

Level II clinical appeals are conducted by a panel of two board-certified psychiatrists, one from ValueOptions and one from GHI, and a Clinical Manager. Panel members have not been involved in the previous determinations of the case. Administrative appeals are reviewed by ValueOptions, in consultation with GHI as needed. A determination will be made within 10 business days of the date ValueOptions received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision.

What is Covered Under the Mental Health and Substance Abuse Program

This section describes Program coverage for inpatient and outpatient care.

Inpatient care

Coverage for inpatient care includes the following medically necessary services:

1. **Hospital Services** for the treatment of mental health and substance abuse are covered.
2. **Residential Treatment Facilities, Halfway Houses and Group Homes.** Covered charges will be payable in full under the network coverage if the admission is certified by ValueOptions. Confinements for these services are covered only under the network portion of the Program. **No benefits are available under non-network coverage.**
3. Mental health care in a **partial hospitalization** program (day or night care center) maintained by an approved facility, on its premises, is covered.
4. **Psychiatric Treatment or Consultation While You Are a Mental Health, Substance Abuse or Medical Inpatient in an Approved Facility.** If you are receiving inpatient mental health/substance abuse treatment from a practitioner who bills separately from the hospital or approved facility, you are covered for no more than one visit per day by your practitioner. This care must be certified independently of the inpatient stay.

   If you are admitted to a hospital for a medical condition and the admission interrupts your certified outpatient mental health and substance abuse care, you may continue to receive certified care from your practitioner during your inpatient stay.
5. **Inpatient Psychiatric Consultations on a Medical Unit.** You are covered for one inpatient mental health visit per day by a practitioner while you are on the medical

unit of a hospital.

Outpatient care

Coverage for outpatient care includes the following medically necessary services:

1. **Emergency Care** at a hospital for treatment of mental health/substance abuse, where you are not admitted as an inpatient following that care, is considered an outpatient service.
2. **Office Visits.** You are covered for office visits for general mental health care. A maximum of one visit per day to the same practitioner will be considered to be a covered service.
3. **Psychiatric Second Opinion.** You are covered for second opinions by a practitioner of equal or higher credentials. Example: Only another psychologist or a psychiatrist may give a second opinion on a psychologist's diagnosis.
4. **Family Sessions.** For each patient's alcoholism, alcohol abuse, or substance abuse treatment program, benefits are allowed for covered family sessions. When the covered alcoholic, alcohol abuser or substance abuser is participating in a Structured Outpatient Substance Abuse Rehabilitation Program, up to 20 family sessions (per year) for family members covered under the same Empire Plan enrollment are included in the program. If the alcoholic, alcohol abuser, or substance abuser is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are eligible for up to 20 family sessions (per year), subject to ValueOptions certification.
5. **Substance Abuse-Structured Outpatient Rehabilitation Program.** Covered benefits are allowed for substance abuse Structured Outpatient Rehabilitation Programs.
6. **Psychological Testing and Evaluations.** These services are covered if ValueOptions requests them and determines that they are medically necessary for the condition(s) indicated. If these services are provided on an outpatient basis, the network provider **must** obtain ValueOptions certification of this care before testing begins. If testing is being provided by a non-network provider, you **must** have your practitioner call ValueOptions and obtain certification of the care before testing begins. There are no network or non-network benefits available if testing is not certified by ValueOptions in advance.
7. **Ambulance Services for Mental Health and Substance Abuse Care.** You are covered for medically necessary hospital-based ambulance services, professional (commercial) ambulance services or organized voluntary ambulance services for transfers from non-network facilities to network facilities approved in advance by ValueOptions. You are also covered for emergency transport to an approved facility.

   You are not covered under this Program for ambulance service to a facility in which you do not receive mental health and substance abuse care.
8. **Crisis Intervention Visits.** Crisis intervention visits are covered under the network coverage and will be payable in full up to the network allowance for up to three visits in a given crisis. ValueOptions reviews documentation of each crisis for approval.

   A statement of necessity satisfactory to ValueOptions must be submitted by the network provider in order for a period of treatment to be considered a crisis.

   Paid in full benefits for these services are available under network coverage only.
9. **Electro-convulsive Therapy.** Electro-convulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All electro-convulsive therapy must be certified by ValueOptions before the service is received.
10. **Medication Management.** You are covered for office visits to a psychiatrist specializing in psychopharmacology for the ongoing review and monitoring of psychiatric medications.
11. **Home-Based Counseling.** You are covered for home-based care provided by a Network Practitioner.

Benefits for these services are available under network coverage only.

12. **Registered Nurse Practitioner.** Services provided by a Registered Nurse Practitioner under the direct supervision of a network physician are covered under the Plan when medically necessary. Services include prescribing medication refills and other services performed within the scope of the Registered Nurse Practitioner's license in the state where the services are performed.

    Benefits for these services are available under network coverage only.

13. **Telephone Counseling.** Telephone counseling provided by a network practitioner is covered.

    Benefits for these services are available under network coverage only.

Schedule of Benefits for Covered Services

VALUE OPTIONS MUST CERTIFY ALL COVERED SERVICES AS MEDICALLY NECESSARY. IF VALUE OPTIONS DOES NOT CERTIFY YOUR INPATIENT OR OUTPATIENT TREATMENT AS MEDICALLY NECESSARY, YOU WILL NOT RECEIVE ANY EMPIRE PLAN BENEFITS AND YOU WILL BE RESPONSIBLE FOR THE FULL COST OF CARE.

NETWORK COVERAGE

If you follow the requirements for network coverage, you are responsible for paying only the following copayments:

a. No copayments are required for inpatient care.

b. You pay the first $10 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.

c. You pay the first $15 charged for any other outpatient visit including Home-Based and Telephone Counseling in place of an office visit, except no copayment is required for:

- Crisis Intervention, up to three per crisis
- Electro-convulsive Therapy - facility and therapist charges, if certified by ValueOptions
- Psychiatric Second Opinion, if requested and certified by ValueOptions
- Ambulance Service
- Mental Health Psychiatric Evaluations, if requested and certified by ValueOptions
- Prescription drugs, if billed by an approved facility
- Home-based counseling when provided in place of inpatient care.

The network provider from whom you receive covered services is responsible for collecting the copayment from you.

Note - Copayments do NOT count toward meeting your non-network coverage deductibles, Basic Medical deductible or Basic Medical Coinsurance Maximum.

Except for the copayment which the network provider obtains directly from you, a network provider does not bill you directly for services or supplies you obtain as a network benefit. Your payment to the network provider is limited to the copayment. The network provider requests payment directly from GHI.

(continued on next page)

YOU ARE RESPONSIBLE FOR OBTAINING VALUE OPTIONS CERTIFICATION FOR CARE OBTAINED FROM A NON-NETWORK PROVIDER

NON-NETWORK COVERAGE

If you do NOT follow the requirements for network coverage, you are responsible for paying the following:

a. The annual deductible for non-network outpatient services, which is $500 per enrollee, $500 per covered spouse/ domestic partner and $500 for all covered dependent children combined, regardless of the number of children.

b. The annual deductible for non-network inpatient services, which is $2,000 per enrollee, $2,000 per covered spouse/ domestic partner and $2,000 for all covered dependent children combined, regardless of the number of children.

ValueOptions will consider non-network coverage for covered expenses after you meet your annual deductible. The non-network allowance is 50 percent of the network allowance.

Note - The amount you pay for inpatient and outpatient services does NOT count toward meeting your Basic Medical deductible or Basic Medical Coinsurance Maximum.

(continued on next page)

NETWORK COVERAGE
(continued)

Maximums

a. Network coverage is unlimited (no maximum) for outpatient mental health and substance abuse care.

b. Network coverage is unlimited (no maximum) for inpatient services for mental health.

c. Inpatient services for treatment of substance abuse are covered for a maximum of three stays per lifetime. Further stays will be considered on a case-by-case basis.

   If a patient transfers from one facility to another, the confinement ends upon discharge from the original facility, unless ValueOptions arranges for the transfer. If ValueOptions arranges for the transfer, treatment at the new facility will be considered a continuation of the same stay.

d. Psychiatric treatment provided by an individual practitioner while you are a mental health, substance abuse or medical inpatient is covered for one visit per day when medically necessary.

NON-NETWORK COVERAGE
(continued)

Maximums

After you meet your Mental Health and Substance Abuse Program deductible, you will be reimbursed up to the non-network allowance, subject to the following maximums:

a. Outpatient services for mental health treatment are covered up to a maximum of 30 visits in a calendar year, inclusive of emergency room visits, outpatient office visits, psychiatric second opinions, psychological testing, mental health psychiatric evaluations, and electro-convulsive therapy.

b. Outpatient services for treatment of substance abuse (including alcohol) are covered up to a maximum of 30 visits in a calendar year, inclusive of Structured Outpatient Rehabilitation Programs and emergency room visits.

c. Inpatient services for mental health treatment are covered up to a maximum of 30 days in a calendar year.

d. Inpatient services for treatment of substance abuse (including alcohol) are covered for a maximum of one confinement in any calendar year and three admissions per lifetime.

   If a patient transfers from one facility to another, the confinement ends upon discharge from the original facility unless ValueOptions arranges for the transfer. If ValueOptions arranges for the transfer, treatment at the new facility will be considered a continuation of the same stay.

e. The annual maximum benefit for substance abuse care, including alcoholism, under the non-network coverage is $50,000 for you, the enrollee, and $50,000 for each of your covered dependents.

f. The lifetime maximum benefit for substance abuse care, including alcoholism, under the non-network coverage is $100,000 for you, the enrollee, and $100,000 for each of your covered dependents.

g. Outpatient treatment sessions for family members of an alcoholic, alcohol abuser, or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

h. No annual or lifetime dollar maximums are applied for mental health treatment under this Plan.

Exclusions and Limitations

Covered services do not include and no benefits will be provided for the following:

1. Expenses incurred prior to your effective date of coverage or after termination of coverage, except under conditions described in the *"Miscellaneous Provisions"* section on page 116.
2. Services or supplies which are not Medically Necessary as defined in the section Meaning of Key Terms.
3. Treatment which is not Mental Health Care or Substance Abuse Care as defined in the section Meaning of Key Terms.
4. Services or supplies which are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.
5. Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non disorder conditions which may be a focus of clinical attention (V codes); except for family visits for substance abuse or alcoholism.
6. Services deemed Experimental, Investigational or Unproven are not covered under this Plan. However, ValueOptions and GHI may deem an Experimental, Investigational or Unproven Service is covered under this Plan for treating a life threatening sickness or condition if they determine that the Experimental, Investigational or Unproven Service at the time of the determination:
   - is proved to be safe with promising efficacy; and
   - is provided in a clinically controlled research setting; and
   - uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
   - Experimental, Investigational or Unproven Services shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. See *"Your right to an External Appeal"* under Miscellaneous Provisions on page 118. If the External Appeal Agent approves coverage of an Experimental, Investigational or Unproven treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Coverage will not be provided for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational treatments provided in connection with such clinical trial.
7. Custodial care, which means the spectrum of services and supplies provided expressly for protection and monitoring in a controlled environment, regardless of setting, and assistance to support essentials of daily living in patients whose persistent symptoms, behavior management, and/or medical and psychological problems result in serious ongoing impairment in central life role function. Such care includes, but is not limited to, state hospital care which is custodial for children who are wards of the state or for enrollees or eligible dependents who are incarcerated in a state hospital facility.
8. Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered.
9. Private duty nursing.
10. Therapy which requires the use of sexual surrogates.
11. Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient treatment reports and statements of medical necessity.
12. Travel, personal hygiene and convenience items such as air conditioners and physical fitness equipment expenses, whether or not recommended by a physician.

13. Charges for services, supplies or treatments that are covered charges under any other portion of the Empire Plan, including but not limited to detoxification of newborns and medically complicated detoxification cases.
14. Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.
15. Services or supplies you receive for which no charge would have been made in the absence of coverage under the Mental Health and Substance Abuse Program, including services from an Employee Assistance Program.
16. Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.
17. Any charges for professional services performed by a person who ordinarily resides in your household or who is related to you, such as a spouse, parent, child, brother or sister or by an individual or institution not defined by ValueOptions as a provider.
18. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you.
19. Conditions resulting from an act of war (declared or undeclared) or an insurrection which occurs after December 5, 1957.
20. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Abuse Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U. S. Department of Veterans' Affairs for a non-service connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

GHI General Provisions

ValueOptions as administrator for GHI is responsible for processing claims at the level of benefits determined by ValueOptions and for performing all other administrative functions under the Empire Plan Mental Health and Substance Abuse Program.

Coordination of Benefits

If you are covered by an additional group health insurance program (such as a program provided by your spouse's employer) which contains coverage for mental health or substance abuse, the Empire Plan will coordinate benefit payments with the other program. One program pays its full benefit as the primary insurer and the other program pays secondary benefits.

Coordination of benefits helps ensure that you receive all the benefits to which you are entitled from each plan, while preventing duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge.

The Empire Plan does not coordinate benefits with any health insurance policy which you or your dependent carries on a direct-pay basis with a private carrier.

The procedures followed when Empire Plan benefits are coordinated with those provided under another program are detailed below. Each of the Empire Plan carriers follows these procedures.

1. "Coordination of Benefits" means that the benefits provided for you under the Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under the Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for a service covered under both group plans.

2. A. "Plan" means a plan which provides benefits or services for or by reason of mental health or substance abuse care and which is:

    1. a group insurance plan; or
    2. a blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
    3. a self-insured or non-insured plan; or
    4. any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
    5. a group service plan; or
    6. a group prepayment plan; or
    7. any other plan which covers people as a group; or
    8. a governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan; or
    9. a mandatory "no fault" automobile insurance plan.

    B. "Order of Benefit Determination" means the procedure used to decide which Plan will determine its benefits before any other plan.

    Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of the Empire Plan which reserves the right to take the benefits or services of other plans into account to determine its benefits, will be treated separately from those parts which do not.

3. When coordination of benefits applies and the Empire Plan is secondary, payment under the Empire Plan will be reduced so that the total of all payments or benefits payable under the Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for the service you receive.
4. Payments under the Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has coordination of benefits or similar provision with the same order of benefit determination as stated in Item 5. Empire Plan benefits are to be determined, in that order, before the benefits under the other plan.
5. When more than one plan covers the person making the claim, the order of benefit payments is determined using the first of the following rules which applies:

    A. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;

    B. When this plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are not divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph C below.)

        1. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
        2. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
        3. If the other plan does not have the rule described in subparagraphs (1) and (2) above, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits:
        4. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

C. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    1. First, the plan of the parent with custody of the child;
    2. Then, the plan of the spouse of the parent with custody of the child; and
    3. Finally, the plan of the parent not having custody of the child; and
    4. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such actual knowledge.

D. The benefits of a plan which cover a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule D is ignored.

E. If none of the rules in A through D above determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

6. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under the Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
7. Any information about covered expenses and benefits which is needed to apply this provision may be given or received without consent of or notice to any person, subject to the provisions in Article 25 of the General Business Law.
8. If an overpayment is made under the Empire Plan before it is learned that you also had other coverage, the Empire Plan carriers have the right to recover the overpayment. You will be required to return any overpayment to the appropriate Empire Plan carrier; or at GHI's discretion, future benefits may be offset by this amount. In most cases, this will be the amount that was paid by the other plan.
9. If payments which should have been made under the Empire Plan have been made under other plans, the party that paid will have the right to recover the appropriate amount from the Empire Plan carriers.
10. There is a further condition which applies under the network provider program. When either Medicare or a plan other than the Empire Plan pays first, and if for any reason the total sum reimbursed by the other plan and the Empire Plan is less than the network provider billed the other plan, the network provider may not charge the balance to you.

Impact of Medicare on this Plan

Even if Medicare or another plan provides your primary coverage, you must follow ValueOptions requirements whenever you will be seeking Empire Plan coverage for mental health or substance abuse services.

Definitions

A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.

B. **Primary Payor** means the plan that will determine the medical benefits which will be payable to you first.

C. **Secondary Payor** means a plan that will determine your medical benefits after the primary payor.

D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.

E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in the General Information section of this book.

F. You will be considered **disabled** if you are eligible for Medicare due to your disability.

G. You will be considered to have **end stage renal disease** if you have permanent kidney failure.

Coverage

When you are eligible for primary coverage under Medicare, the benefits under this Plan may change.

*Please refer to the General Information section of this book for information on when you must **enroll** for Medicare and when Medicare becomes your primary coverage.* **If you or your dependent is eligible for primary Medicare coverage – even if you or your dependent fails to enroll – your covered medical expenses will be reduced by the amount available under Medicare, and GHI will consider the balance for payment, subject to copayment, deductible and coinsurance.**

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare+Choice (Risk) Contract, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained in the last paragraph of this section, *"Medicare+Choice (formerly Medicare Risk Contract)"* below.

A. **Retired Employees and/or their Dependents** — If you or your dependents are eligible for primary coverage under Medicare – even if you or they fail to enroll – your covered medical expenses will be reduced by the amount that would have been paid by Medicare, and GHI will consider the balance for payment, subject to copayment, deductible and coinsurance.

   If the provider has agreed to accept Medicare assignment, covered expenses will be based on the provider's reasonable charge or the amount approved by Medicare, whichever is less. If the provider has not agreed to accept Medicare assignment, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations.

   No benefits will be paid for services or supplies provided by a skilled nursing facility.

B. **Active State Employees and/or their Dependents** — This Plan will automatically be the primary payor for active employees, regardless of age, and for the employee's enrolled dependents (except for a domestic partner eligible for Medicare due to age) unless end stage renal disease provisions apply; Medicare, the secondary payor. As the primary payor, GHI will pay benefits for covered medical expenses under this Plan; as secondary payor, Medicare's benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

   The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

   Note to domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare eligible due to disability, NYSHIP is primary.

C. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must be enrolled in Parts A and B of Medicare when first eligible and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.

D. **End Stage Renal Disease.** For those eligible for Medicare due to end stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first 30 months of treatment, then Medicare becomes primary. See *"Medicare end stage renal disease coordination"* on page 27 of the General Information section. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

Medicare+Choice (formerly Medicare Risk Contract)

For Medicare-primary Empire Plan enrollees who also enroll in a Health Maintenance Organization under a Medicare+Choice Contract. If you or your dependent enrolls in a Health Maintenance Organization under a Medicare+Choice Contract, the Empire Plan will not provide benefits for any services available through your HMO or services that would have been covered by your HMO if you had complied with the HMO's requirements for coverage. Covered medical expenses under the Empire Plan are limited to expenses not covered under your Medicare+Choice Contract with the HMO. If your HMO Medicare+Choice Contract has a Point-of-Service option that provides partial coverage for services you receive outside the HMO, covered medical expenses under the Empire Plan are limited to the difference between the HMO's payment and the amount of covered expenses under the Empire Plan.

Claims

Claim payment for covered services

Claim payments for covered services you receive under this Program will be made only as follows:

1. **Network Coverage:** When you receive network coverage, GHI will make any payment due under this Program directly to the provider, except for the copayment amount which you pay to the provider.
2. **Non-network Coverage:** When you receive non-network coverage, any payment due under the Program will be made ONLY to you. You are responsible for payment of charges at the time they are billed to you. You must file a claim with ValueOptions for services rendered under non-network coverage in order to receive reimbursement. GHI pays you the non-network allowance for the covered service you obtained. You are always required to pay the inpatient and/or outpatient deductible and the amount billed to you in excess of the non-network allowance. Also, you are ultimately responsible for paying your provider any amount not paid by GHI. However, GHI will pay the non-network allowance directly to an approved facility in lieu of paying you.
3. **Assignment Prohibited:** Your right under this Program to receive reimbursement for outpatient covered services when such services are provided under non-network coverage, except inpatient services and partial hospitalization, may not be assigned or otherwise transferred to any other person or entity including, without limitation, any such provider. Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, GHI or ValueOptions.

How, When and Where to Submit Claims

How

If you use network coverage, all you have to do is ensure that the provider has accurate and up-to-date personal information needed to complete the claim form – name, address, identification number, signature. Your provider fills out the form and sends it directly to ValueOptions. The claim forms are generally in each provider's office.

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

ValueOptions
P.O. Box 778
Troy, New York 12181-0778

or

You may call ValueOptions Customer Service at:

1-800-446-3995

For non-network coverage, have the provider fill in all the information asked for on the claim form and sign it. If the form is not filled out by the provider and bills are submitted, the bills must include all the information asked for on the claim form. Missing information will delay processing of your claim. No benefits will be paid unless care is certified by ValueOptions.

When

If you are enrolled in Medicare, an "Explanation of Medicare Benefits" form **must be submitted with the completed claim form or detailed bills** to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the "Explanation of Medicare Benefits" form and other documents for your records.

Remember - If you are enrolled with Medicare as the primary payor, bills must be submitted to Medicare first.

1. If you use network coverage, your provider will submit a claim to ValueOptions.
2. If you use non-network coverage, you must meet the Mental Health and Substance Abuse Program annual deductible before the claims are paid. This deductible is separate from the other Empire Plan annual deductibles.

   Claims must be submitted to either ValueOptions or Medicare, if applicable, within 90 days after the end of the calendar year in which covered expenses were incurred. If the claim is first sent to Medicare, it must be submitted to ValueOptions within 90 days after Medicare processes the claim.

   Benefits will not be paid for claims submitted after the 90 days regardless of whether you or a provider submits the claim unless meeting this deadline has not been reasonably possible (for example, due to your illness).

Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, a "Medicare Explanation of Benefits" form to: ValueOptions, P.O. Box 778, Troy, New York 12181-0778.

Fraud

Any person who intentionally defrauds an insurance company by filing a claim which contains false or misleading information, or conceals information which is necessary to properly examine a claim has committed a crime.

Verification of claims information

ValueOptions and GHI have the right to request from approved facilities, practitioners or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

Questions

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call ValueOptions at the following toll-free number: 1-800-446-3995.

COBRA: Continuation of Coverage

Your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you and your covered dependents, are explained in your NYSHIP General Information Book.

Miscellaneous Provisions

Confined on effective date of coverage

If you become covered under this Plan and on that date are confined in a hospital or similar facility for care or treatment or are confined at home under the care of a doctor for an illness or injury, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

Benefits after termination of coverage

If you are Totally Disabled due to a mental health or substance abuse condition on the date coverage ends on your account, GHI will pay benefits for covered expenses for that Total Disability, on the same basis as if coverage had continued without change, until

the day you are no longer Totally Disabled or 90 days after the day your coverage ended, whichever is earlier.

"Total Disability" and "Totally Disabled" mean that because of a mental health/substance abuse condition you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

Confined on date of change of options

"Option" means your choice under the New York State Health Insurance Program of either the Empire Plan, which includes the Mental Health and Substance Abuse Program, or a Health Maintenance Organization (HMO). See your NYSHIP General Information Book for information on option transfer.

If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or similar facility for mental health/substance abuse care or confined at home under the care of a practitioner for mental health/substance abuse care:

a. if the transfer is out of the Empire Plan, and you are confined on the day coverage ends, benefits will end on the effective date of option transfer; and

b. if the transfer is into the Empire Plan, benefits under the Mental Health and Substance Abuse Program are payable for covered expenses to the extent they exceed or are not paid through your former HMO.

Termination of coverage

1. Coverage will end when you are no longer eligible to participate in the Empire Plan. Refer to your NYSHIP General Information Book.
2. If this Program ends, your coverage will end.
3. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your NYSHIP General Information Book.
4. If a payment which is required by the State of New York for coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim which is incurred before your coverage ends will not be affected.

Refund to GHI for overpayment of benefits

If GHI pays benefits under this Program for covered expenses incurred on your account, and it is found that GHI paid more benefits than should have been paid because all or some of those expenses were not paid by you, or you were also paid for all or some of those expenses by another source, GHI will have the right to a refund from you.

The amount of the refund is the difference between the amount of benefits paid by GHI for those expenses and the amount of benefits which should have been paid by GHI for those expenses.

If benefits were paid by GHI for expenses not covered by this Program, GHI will have the right to a refund from you.

Time limit for starting lawsuits

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive notice that benefits have been denied.

Appeals: 60-day deadline

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 notice of denial of the certification or claim to:

ValueOptions
Att: Customer Service
433 River Street, Suite 200
Troy, New York 12180

When requesting a review, please state the reason you believe the certification or claim was improperly denied and submit any data, questions or comments you deem appropriate.

Please refer to *"Certification denial and appeal process: deadlines apply"* on page 105 for information about the appeals process.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, Agency Building One, Empire State Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9am - 5pm.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if GHI has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary

If you have been denied coverage on the basis that the service is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedures was presented for consideration, GHI must have upheld the denial; **or** you and GHI must agree in writing to waive any internal appeal.

Your right to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

A. The service must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedures was presented for consideration, GHI must have upheld the denial; **or** you and GHI must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation - your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable); or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal process

If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and GHI have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. GHI will provide an external appeal application with the final adverse determination issued through GHI's internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which GHI based its denial, the External Appeal Agent will share this information with GHI in order for it to exercise its right to reconsider its decision. If GHI chooses to exercise this right, GHI will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), GHI does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or GHI. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and GHI by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision. If the External Appeal Agent overturns GHI's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, GHI will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, GHI will only cover the costs of services required to provide treatment to you according to the design of the trial. GHI shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and GHI. The External Appeal Agent's decision is admissible in any court proceeding.

GHI will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. GHI will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an External Appeal

It is YOUR RESPONSIBILITY to initiate the external appeal process.You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

45-day deadline

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from GHI that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. GHI has no authority to grant an extension of this deadline.

CIGNA/Connecticut General Life Insurance Company Certificate of Insurance

This is to certify that, subject to the terms of Group Policy No. 57830PD, issued to the Policyholder named below, active employees and their eligible dependents enrolled through Participating Employers who are enrolled in the New York State Health Insurance Program's Empire Plan Prescription Drug Program and COBRA enrollees with their benefits are insured for the benefits described below.

The State of New York (herein called the State) is the Policyholder.

The benefits for which you are insured are set forth in this certificate.
The benefits shown in this certificate became effective January 1, 2001.

Insurance takes effect only if you are eligible for it, you elect it and you make a contribution for it, as required.

This certificate takes the place of any prior documents issued to you covering your Empire Plan prescription drug insurance.

Benefits are payable as described under Non-participating pharmacies in this certificate. Itemized bills may be required as part of proof of claim.

This Insurance evidenced by this certificate provides Prescription Drug Insurance only.

Florida residents please note

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Form No. TC 10380-02

Section V:
CIGNA CERTIFICATE OF INSURANCE
Empire Plan Prescription Drug Program

This section does not apply to you if you have prescription drug coverage through a union Employee Benefit Fund.

CIGNA/Connecticut General Life Insurance Company insures the Empire Plan Prescription Drug Program. Express Scripts, Inc. is the program administrator. Express Scripts Mail Service is the mail service pharmacy.

Meaning of Terms Used

A. **This Program** means the Empire Plan Prescription Drug Program described in this certificate.

B. The word **you, your,** or **yours** refers to you, the eligible enrollee to whom this certificate is issued. It also refers to any members of your family who are covered under this Program. For information on eligibility, refer to your New York State Health Insurance Program General Information Book.

C. **Doctor** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed, without limitations or restrictions, to practice medicine. For benefits provided under this Policy, and for no other purpose, Doctor also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

D. **Pharmacist** means a person who is legally licensed to practice the profession of pharmacy. He or she must regularly practice such profession in a pharmacy.

E. **Pharmacy** means any establishment, other than the mail service pharmacy, that is registered as a pharmacy with the appropriate state licensing agency or is a Veterans' Affairs medical center or hospital pharmacy. Drugs described in the section *"What Is Covered"* must be regularly dispensed from the pharmacy by a pharmacist.

F. **Participating Pharmacy** means any pharmacy, other than the mail service pharmacy, which is in the PPO/Select Network and (1) regularly dispenses drugs in the section *"What Is Covered."* and (2) has entered into an agreement with Express Scripts to dispense drugs per the terms of the contract.

G. **Non-Participating Pharmacy** means any pharmacy other than the mail service pharmacy which has not entered into an agreement with Express Scripts to dispense drugs per the terms of the contract. It must regularly dispense drugs described in the section *"What Is Covered."*

H. **Mail Service Pharmacy** means the specific mail service pharmacy, Express Scripts Mail Service. It is located in New York State. It shall dispense drugs per the terms of this certificate and in accord with the laws, rules and regulations which govern pharmacy practice in New York State.

I. **Prescription Order** means:

   1. the written or oral request for drugs issued by a Doctor duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed; or
   2. an authorized refill of that order.

J. **Brand-Name Drug** means any prescription drug that is mainly identified and marketed under a protected brand name or trade name by an individual drug manufacturer.

K. **Generic Drug** means any prescription drug that is called by its official, established, nonproprietary name, not by a brand name chosen by the manufacturer. Such drugs include AB-rated generics and non-AB-rated generics approved by the U.S. Food and Drug Administration as:

   1. having the same active ingredient as;

2. being therapeutically equivalent to; and
3. in the case of AB-rated generics, being bioequivalent to their brand-name counterparts.

L. **Controlled Drug** means a drug designated by federal law or New York State law as a Class I, II, III, IV or V substance. A controlled drug includes but is not limited to:
1. some tranquilizers;
2. stimulants; and
3. pain medications.

M. **Medically Necessary** means any drug which, as determined by Express Scripts is: (1) provided for the diagnosis or treatment of a medical condition; (2) appropriate for the symptoms, diagnosis or treatment of a medical condition, and (3) within the standards of generally accepted health care practice.

If Express Scripts denies your claim for benefits for a drug or drugs on the basis that the drug is not medically necessary, benefits will be paid under the Empire Plan Prescription Drug program if:

- Another Empire Plan carrier has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug, and has paid benefits in accordance with Empire Plan provisions on your behalf for a medical procedure or service related to the administration of that drug; or
- Another Empire Plan carrier has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug, and has provided to you a written pre-authorization of benefits based on their determination of medical necessity, stating that the Empire Plan Benefits will be available to you for a medical procedure or service related to the administration of that drug; and
- You provide to Express Scripts proof of payment or pre-authorization of benefits from the other Empire Plan carrier based on their determination of medical necessity regarding the availability of Empire Plan benefits to you for a medical procedure or service related to the administration of that drug.

In addition, the above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

N. **No-Fault Motor Vehicle Plan** means a motor vehicle plan which is required by law. It provides medical or dental care payments which are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

O. **Workers' Compensation Law** means a law which requires employees to be covered, at the expense of the employer, for benefits in case they are disabled because of accident or sickness, or billed due to a cause connected with their employment.

The information below explains your benefits and responsibilities in detail.

Your Benefits and Responsibilities

Copayments: $5 generic/$15 brand-name

Your copayment for up to a 90-day supply is $5 for generic drugs and $15 for brand-name drugs with no generic equivalent. For brand-name drugs with a generic equivalent, you pay a $15 copayment plus the difference in cost between the brand-name drug and its generic equivalent. This cost difference can be substantial.

The copayment applies to prescriptions dispensed at a participating pharmacy and at Express Scripts Mail Service. One copayment covers up to a 90-day supply. One copayment covers a refill for up to a 90-day supply. Refills are valid for up to one year from the date the prescription is written.

Mandatory Generic Substitution

When your prescription is written for a brand-name drug that has a generic equivalent, Empire Plan coverage will be limited to the cost of the drug's generic equivalent. The Plan will cover the cost of brand-name drugs which have no generic equivalent.

For example, when you use your card at a participating pharmacy, if your prescription is written for:

- **A brand-name drug with a generic equivalent** – You will pay a $15 copayment *plus* the difference in cost between the brand-name and generic drug, not to exceed the full cost of the drug. This cost difference can be substantial.

  The following brand-name drugs are excluded from Mandatory Generic Substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Slo-Bid, Synthroid, Tegretol and Theo-Dur. You pay only the $15 copayment.
- **A brand-name drug with no generic equivalent** – You pay only the $15 copayment.
- **A generic drug** – You pay only the $5 copayment.

Remember, if your doctor insists on prescribing a brand-name drug that has a generic equivalent, you will pay your $15 copayment plus the difference in cost between the brand-name and the generic drug.

If your doctor feels it is medically necessary for you or your family member to have a brand-name drug (that has a generic equivalent), you can appeal the Mandatory Generic Substitution requirement. Call 1-800-964-1888 for an appeal form which you and your doctor must complete. Or, you can write for a generic appeal form to:

Empire Plan Prescription Drug Program
P.O. Box 749
Troy, New York 12181-0749.

Act promptly. Express Scripts will go back only 30 days from the date of receipt of a completed appeals form to adjust claims.

If your appeal is granted, you can fill your prescription for the brand-name drug at an Empire Plan/Express Scripts participating pharmacy or through the mail service pharmacy and pay only the $15 copayment. If your appeal is denied, you can make a second appeal to be reviewed by CIGNA, the program insurer.

Controlled drugs

Prescriptions for supplies of controlled drugs (drugs classified by federal or New York State law such as sedatives, sleeping pills, narcotics or pain-control medicines) can be filled through a participating pharmacy, Express Scripts Mail Service or a non-participating pharmacy.

Prior authorization

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for the following drugs purchased at a pharmacy:

- BCG Live
- Ceredase or Cerezyme
- Drugs for the treatment of impotency
- Enbrel
- Epoetin
- Human Growth Hormone
- Immune Globulin
- Lamisil
- Prolastin
- Pulmozyme
- Sporanox

These drugs can have medical results of immeasurable value, but they are sometimes prescribed inappropriately. The Prior Authorization Program ensures that these drugs are used appropriately, for medically necessary treatments.

You must call 1-800-964-1888 for prior authorization for certain drugs

When a claim from a participating retail or mail service pharmacy is submitted for one of these drugs, the review process is initiated when the pharmacist receives the message, "Prior authorization required." The pharmacist, you, a member of your family, your doctor or your doctor's staff must call Express Scripts at 1-800-964-1888 to begin the review process. However, you are ultimately responsible for getting prior authorization if your doctor prescribes a drug on the prior authorization list.

If the prior authorization review results in authorization for payment, you will receive Empire Plan Prescription Drug Program benefits for the drug. If the payment is not authorized, no Empire Plan Prescription Drug Program benefits will be paid for the drug.

An appeal process will allow you or your doctor to ask for further review if authorization is not granted. You may call Express Scripts at 1-800-964-1888 for information on how to initiate an appeal.

The Prior Authorization requirements apply whenever you use Empire Plan Prescription Drug Program benefits for these drugs. You must call for Prior Authorization whether you use your New York Government Employee Benefit Card or will be filing a claim for direct reimbursement.

Supply and coverage limits

You can have your prescriptions filled for up to a 90-day supply, with refills for up to one year.

What is covered

You are covered for the following prescription drugs or medicines when they are medically necessary:

A. Federal Legend Drugs. Drugs or medicines whose labels must bear the legend: *Caution: Federal Law prohibits dispensing without a prescription.*

B. State Restricted Drugs. Drugs or medicines which can be dispensed in accord with New York State Law (or by the laws of the state or jurisdiction in which the prescription is filled) by prescription only.

C. Compounded Medications. Drugs or medicine mixtures which have in them:

1. at least one Federal Legend Drug or State Restricted Drug; and
2. a combination of ingredients which require a prescription by law when compounded into a specific dosage form for an individual patient at the direction of a doctor.

The mixture must be in a therapeutic amount.

If liquid, it must also include the weighing of at least one solid, or the measuring/mixing of at least three liquid ingredients.

D. Injectable insulin.

E. Oral, injectable, or surgically implanted contraceptives which are Federal Legend Drugs.

F. Vitamins which are Federal Legend Drugs.

Please refer to the section Exclusions and Limitations below for conditions under which benefits for the above drugs are not available.

Exclusions and Limitations

Charges for the following items are **not** covered expenses:

A. Drugs obtained with no prescription order, except insulin.

B. Drugs taken or given at the time and place of the prescription order.

C. Drugs provided or required by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay.

D. Drugs for which there is no charge or legal obligation to pay in the absence of insurance.

E. Drugs administered to you by the facility while a patient in a licensed hospital; rest home; sanitarium; extended care facility; convalescent hospital; nursing home; or similar facility.

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

F. Any drug refill which is more than the number approved by the doctor.

G. Diaphragms, contraceptive jellies and ointments, foams or devices, prescribed for any reason.

H. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments, or other non-medicinal substances), regardless of their intended use.

I. The administration of any Federal Legend Drug or injectable insulin.

J. Any drug refill which is dispensed more than one year after the original date of the prescription order.

K. Any drug labeled "Caution: Limited by Federal Law to Investigational Use," or experimental drugs except for drugs used for the treatment of cancer as specified in 3221(l)12 of New York State Insurance Law as may be amended: Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

   Experimental or investigational drugs shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. For external appeal provisions, see *"Your right to an External Appeal"* under Miscellaneous Provisions on page 131. If the External Appeal Agent approves coverage of an experimental or investigational drug that is part of a clinical trial, only the costs of the drug will be covered. Coverage will not be provided for the costs of experimental or investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Empire Plan for non-experimental or non-investigational drugs provided in connection with such clinical trial.

L. Immunizing agents, biological sera, blood or blood plasma, except immune globulin.

M. Any drug which a doctor or other health professional is not authorized by his or her license to prescribe.

N. Drugs for an injury or sickness related to employment for which benefits are provided by any State or Federal workers' compensation, employers liability or occupational disease law or under Medicare or other governmental program, except Medicaid.

O. Drugs purchased prior to the start of coverage or after coverage ends.

   However, if the person is totally disabled on the date this insurance ends, see *"Benefits After Termination of Coverage"* on page 130.

P. Any drug prescribed and/or dispensed in violation of state or federal law.

Q. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include but are not limited to:

   1. Non-amphetamine anorexiants, except for morbid obesity.
   2. Amphetamines that are prescribed for weight loss, except for morbid obesity.
   3. Rogaine or other similar products for hair growth.
   4. Retinoic Acid (Retin-A) for prevention of skin wrinkling.

R. Any non-medically necessary drugs.

IMPORTANT: See your NYSHIP General Information Book and Empire Plan Certificates for other conditions that may affect this coverage. See especially the Home Care Advocacy Program (HCAP) section of your United HealthCare Certificate for coverage for prescription drugs billed by a home care agency.

How to Use
Your Empire Plan Prescription Drug Program

When your doctor prescribes a medically necessary drug covered under the Empire Plan, you can fill the prescription for a supply of up to 90 days and refills for 90-day supplies for up to one year in one of three ways: at a participating pharmacy, at a non-participating pharmacy or through Express Scripts Mail Service.

Participating pharmacies

You can use your New York Government Employee Benefit Card for covered prescription drugs at Empire Plan/Express Scripts participating pharmacies that are in the PPO/Select Network. Be sure your pharmacist knows that you and your family have Empire Plan Prescription Drug Program coverage.

To find a participating pharmacy, check with your pharmacist or call Express Scripts at 1-800-964-1888. Many retail pharmacies in New York State participate in this program. Many out-of-State pharmacies participate, as well.

All Express Scripts participating pharmacies can fill prescriptions for supplies of up to 90 days. Refills are valid for up to a year from the date the prescription is written. Only one copayment applies for up to a 90-day supply.

Non-participating pharmacies

You can use a non-participating pharmacy or pay the full amount for your prescription at a participating pharmacy (instead of using your New York Government Employee Benefit Card) and fill out a claim for reimbursement.

In almost all cases, you will not be reimbursed the total amount you paid for the prescription. To reduce your out-of-pocket expenses, use your New York Government Employee Benefit Card whenever possible.

Several factors affect the amount of your reimbursement. If your prescription was filled with:

- a generic drug, a brand-name drug with no generic equivalent, or insulin, you will be reimbursed up to the amount this program would reimburse a participating pharmacy for that prescription as calculated using the standard reimbursement rates for affiliated pharmacies less the applicable copayment.
- a brand-name drug with a generic equivalent (other than drugs excluded from Mandatory Generic Substitution), you will be reimbursed up to the amount this program would reimburse a participating pharmacy for filling the prescription with that drug's generic equivalent as calculated using the standard reimbursement rates for affiliated pharmacies less the applicable copayment.

Out-of-pocket expenses: When you use a non-participating pharmacy or pay the full amount for your prescription at a participating pharmacy, you are responsible for the difference between the amount charged and the amount you are reimbursed under this Program.

For claim forms, call Express Scripts at 1-800-964-1888. Mail the completed form with your bills or receipts to:

Empire Plan Prescription Drug Program
Claims Review Unit
P.O. Box 1180
Troy, New York 12181-1180

Deadline for filing claims

Claims must be submitted within 90 days after the end of the calendar year in which the drugs were purchased, or 90 days after another plan processes your claim, whichever is later, unless it was not reasonably possible for you to meet this deadline (for example, due to your illness).

Mail service pharmacy

You can order your covered prescription drugs by mail from your mail service pharmacy, Express Scripts Mail Service, and pay by credit card, check or money order.

You can order and receive up to a 90-day supply of your prescriptions, shipped by first class mail or private carrier. For refill orders and envelopes, call a Customer Service Representative at the nationwide, toll-free number, 1-800-964-1888, 24 hours seven days a week.

If you need to speak to a pharmacist about your mail service prescription, call 1-800-964-1888, Monday–Friday, 8:30 am–5 pm. At other times, a pharmacist is on call only for emergencies, such as questions about dosage, a change in the appearance of medication or drug interactions.

The mail service address is:

Express Scripts Mail Service
P.O. Box 298
Troy, New York 12181-0298

Call the Empire Plan Prescription Drug Program

For questions about your Empire Plan Prescription Drug Program, call Express Scripts at **1-800-964-1888.**

Call 24 hours a day, 7 days a week if you need to:

- Verify your eligibility
- Locate an Empire Plan/Express Scripts participating pharmacy
- Request prior authorization
- Find out if your claims have been paid
- Reach the mail service pharmacy
- Talk to a customer service representative

Mail Service Questions:

To talk to a pharmacist about your mail service prescription call:

- Monday–Friday, 8:30 am–5 pm.
- To reach a pharmacist for emergencies after hours, call Express Scripts. The pharmacist on-call will be paged and will return your call.

TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: **1-800-840-7879.**

Coordination of Benefits

1. **Coordination of Benefits** means that the benefits provided for you under the Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of Coordination of Benefits is to avoid duplicate benefit payments so that the total payment under the Empire Plan and under another plan is not more than the reasonable and customary charge for a service covered under both group plans.
2. Definitions
   A. **Plan** means a plan which provides benefits or services for or by reason of medical or dental care and which is:
      1. a group insurance plan; or
      2. a blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
      3. a self-insured or non-insured plan; or
      4. any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
      5. a group service plan; or
      6. a group prepayment plan; or
      7. any other plan which covers people as a group; or

8. a governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non governmental plan.

B. **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of the Empire Plan which reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts which do not.

3. When coordination of benefits applies and the Empire Plan is secondary, payment under the Empire Plan will be reduced so that the total of all payments or benefits payable under the Empire Plan and under another plan is not more than the reasonable and customary charge for the service you receive.
4. Payments under the Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a Coordination of Benefits or similar provision with the same order of benefit determination as stated in Item 5 and, under that order of benefit determination, the benefits under the Empire Plan are to be determined before the benefits under the other plan.
5. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules which applies:

A. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;

B. When this Plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are **not** divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph C below.)

1. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
2. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
3. If the other plan does not have the rule described in subparagraphs (1) and (2) above, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
4. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

C. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the plan of the parent with custody of the child;
2. Then, the plan of the spouse of the parent with custody of the child; and
3. Finally, the plan of the parent not having custody of the child; and
4. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does apply to any benefits paid or provided before the entity had such knowledge.

D. The benefits of a plan which covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this
rule D is ignored.

E. If none of the rules in A through D above determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

6. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under the Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
7. Any information about covered expenses and benefits which is needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.
8. If an overpayment is made under the Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
9. If payments which should have been made under the Empire Plan have been made under other plans, the party which made the other payments will have the right to receive any amounts which are considered proper under this provision.

Miscellaneous Provisions

Termination of coverage

1. Coverage will end when you are no longer eligible to participate in this Program. Refer to the eligibility section of your NYSHIP General Information Book.

   Under certain conditions, you may be eligible to continue coverage under this Program temporarily after eligibility ends. Refer to the COBRA section of your NYSHIP General Information Book.
2. If this Program ends, your coverage will end.
3. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your NYSHIP General Information Book.

   Under certain conditions, dependent(s) of employees or former employees may be eligible to continue coverage under this Program temporarily after eligibility ends. Refer to the COBRA section of your NYSHIP General Information Book.
4. If a payment which is required from you toward the cost of the coverage is not made, the coverage will end on the last day of the period for which a payment was made.
5. If coverage ends, any claim incurred before your coverage ends, for any reason, will not be affected; also, see Benefits After Termination of Coverage.

Benefits after termination of coverage

You may be Totally Disabled on the date coverage ends on your account. If so, benefits will be provided on the same basis as if coverage had continued with no change until the day you are no longer Totally Disabled or for three months after the date your coverage ended, whichever is earlier.

Totally Disabled means that, because of a sickness or injury, you, the enrollee cannot do your job, or any other work for which you might be trained, or your dependent cannot do his or her usual duties.

Request for repayment of benefits

Express Scripts will seek reimbursement from you for any money paid on behalf of you or your dependents for expenses incurred after loss of eligibility for benefits for any reason. Use of the New York Government Employee Benefit Card after eligibility ends constitutes fraud.

Audits/prescription benefit records

From time to time, Express Scripts may ask you to verify receipt of particular drugs from participating pharmacies, or from Express Scripts Mail Service. These requests are part of the auditing process. Your cooperation may be helpful in identifying fraudulent practices or unnecessary charges to your plan. All such personal information will remain confidential.

Legal action

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive written notice that benefits have been denied.

Claims appeal: 60-day deadline

In the event a claim has been denied, in whole or in part, you can request a review of your claim. This request for review should be sent to the Claims Review Unit at the following address, within 60 days after you receive notice of denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate.

To request a review of your claim, write to:

Empire Plan Prescription Drug Program
Claims Review Unit
P.O. Box 1180
Troy, New York 12181-1180

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, Agency Building One, Empire State Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9am - 5pm.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if CIGNA has denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

Your right to appeal a determination that a drug is not medically necessary

If you have been denied coverage on the basis that the prescription drug is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

A. The prescription drug must otherwise be covered under the Empire Plan Prescription Drug Program; and

B. You must have received a final adverse determination through the internal appeal process described above and CIGNA must have upheld the denial **or** you and CIGNA must agree in writing to waive any internal appeal.

Your rights to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the drug is experimental or investigational, you must satisfy the following two criteria:

A. The prescription drug must otherwise be covered under the Empire Plan Prescription Drug Program; and

B. You must have received a final adverse determination through the internal appeal process described above and CIGNA must have upheld the denial **or** you and CIGNA must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard drugs are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard drug or procedure covered by the program.

In addition, your attending physician must have recommended a drug that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered drug (only certain documents will be considered in support of this recommendation - your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal process

If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the prescription drug is not medically necessary or is an experimental or investigational drug, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and CIGNA have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. CIGNA will provide an external appeal application with the final adverse determination issued through CIGNA's internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Express Scripts based its denial, the External Appeal Agent will share this information with CIGNA in order for it to exercise its right to reconsider its decision. If CIGNA chooses to exercise this right, CIGNA will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), CIGNA does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional

information from you, your physician or CIGNA. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the prescription drug that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and CIGNA by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision. If the External Appeal Agent overturns CIGNA's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, CIGNA will provide coverage subject to the other terms and conditions of the program.

The External Appeal Agent's decision is binding on both you and CIGNA. The External Appeal Agent's decision is admissible in any court proceeding.

CIGNA will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. CIGNA will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an External Appeal

It is YOUR RESPONSIBILITY to initiate the external appeal process.You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

45-day deadline

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from CIGNA that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. CIGNA has no authority to grant an extension of this deadline.

More About Your Empire Plan Prescription Drug Program
Drug Utilization Review (DUR)

Prescription drugs can work wonders in curing ailments and keeping you healthy – often at a cost much lower than surgery or other procedures. But they can also cause serious harm when taken in the wrong dosage or in a harmful combination with another drug.

DUR identifies possible problems

To help avoid problems, your Empire Plan Prescription Drug Program includes a Drug Utilization Review (DUR) program performed by Express Scripts – to ensure that your medications are appropriate and your benefit dollars are being spent wisely.

This program reviews your prescriptions and monitors your use of medications to spot possible problems. Express Scripts then informs physicians and pharmacists about possible medical problems.

The DUR process

This review process asks:

- Is the prescription written for the recommended daily dose?
- Is the patient already taking another drug that might conflict with the newly prescribed drug?
- Does the patient's prescription drug record indicate a medical condition that might be made worse by this drug?
- Has the age of the patient been taken into account in prescribing this medication?

When you use your card

When you use your card at a participating pharmacy and the pharmacist enters the information into the computer, the computer system will review your recent Empire Plan Prescription Drug Program medication history. If a possible problem is found, a warning message will be flashed to your pharmacist.

The pharmacist may talk with you and your doctor. Once any issues are resolved, the appropriate medication can be dispensed.

Safety

In addition, Express Scripts conducts a "behind the scenes" safety review to look at any long-term effects of your drug treatment. If a potential problem is spotted, the information is reviewed by a clinical pharmacist, who notifies your doctor of the possible risks. If two prescribing doctors are involved, both will be notified of the potential problem.

This process is designed to safeguard your health, and it helps your doctor make more informed decisions about your prescription drugs.

Confidential service

Confidentiality is key. You can be assured that Express Scripts conducts these reviews confidentially and that pertinent information is shared only with your pharmacist and doctor.

Using the Preferred Drug List

One way you can help control the rapidly increasing cost of prescription drugs is by encouraging your physician and pharmacist to use a preferred list of drugs – or formulary.

This list offers alternatives which are safe and effective equivalents to higher cost drugs. The drugs listed have been determined by a nationwide panel of pharmacists and physicians to be safe and effective for treating disease and reducing drug therapy cost.

For example, one antibiotic can cost $70. Another, equally safe and effective for many of the same conditions, can cost just $10.

Express Scripts will send this preferred list of drugs to physicians and pharmacists to use in selecting drugs for you. They are encouraged – but not required – to use this list. You will receive your prescription regardless of whether it is on the preferred list.

Help control the rising cost of the prescription drug program. If your doctor prescribes a drug on the list, you can be assured of quality drug therapy and cost-effective care.

Education is the Right Prescription

For patients

It's important that you understand the drugs being prescribed for you – what they will do and how they should be taken. To help you with that understanding, Express Scripts will provide specially designed prescription drug information you can discuss with your doctor.

Express Scripts' clinical pharmacists will review patients' medication profiles. Those patients who would benefit the most from educational intervention will be mailed information confidentially. This information will explain the risks, benefits and uses of important medications such as anti-ulcer drugs, anti-inflammatory medications, tranquilizers, sleep medications and anti-depressants.

For physicians

To help your doctor keep up to date on the most current information on prescription drugs, Express Scripts has a physician education program.

Express Scripts, on behalf of the Empire Plan, will periodically review doctors' prescribing records. They'll identify where doctors might benefit from unbiased information about different medications and send them written educational materials or arrange for a clinical pharmacist to meet with them.

Empire Plan Copayments for Active Employees enrolled through Participating Employers

Here's a guide to your copayments for services covered under the Empire Plan. See your Empire Plan Certificates for details.

Services by Empire Plan Participating Providers

You pay only your copayment when you choose Empire Plan Participating Providers for covered services. Check your directory for Participating Providers in your geographic area, or ask your provider. For Empire Plan Participating Providers in other areas and to check a provider's current status, call United HealthCare at 1-800-942-4640 or use the Participating Provider Directory on the Internet at http://www.cs.state.ny.us.

Office Visit $10

Office Surgery $10

(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.)

Radiology, Single or Series;
Diagnostic Laboratory Tests $10

(If Outpatient Radiology and Outpatient Diagnostic Laboratory Tests are charged by a Participating Provider during a single visit, **only one** copayment will apply.)

Mammography, according to guidelines $10

Adult Immunizations $10

Allergen Immunotherapy .....No Copay

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

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

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

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

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

Free-standing Cardiac
Rehabilitation Center visit.....$10

Urgent Care Center $10

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

Medically appropriate local professional/commercial ambulance transportation $35

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

You pay only your copayment when you choose MPN network providers for covered services. To find an MPN network provider, ask the provider directly, or call United HealthCare at 1-800-942-4640. Internet: http://www.cs.state.ny.us.

Office Visit $10

Radiology; Diagnostic Laboratory Tests $10

(If Radiology and Laboratory Tests are charged by an MPN network provider during a single visit, **only one** copayment will apply.)

Hospital Outpatient Department Services

Emergency Care $35*

(The $35 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.)

Surgery $25*

Diagnostic Laboratory Tests $25*

Diagnostic Radiology (including mammography, according to guidelines) $25*

Administration of Desferal for
Cooley's Anemia $25*

Physical Therapy (following related surgery or hospitalization) $10

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

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

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

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

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

Call ValueOptions at 1-800-446-3995 before beginning treatment.

Visit to Outpatient Substance Abuse
Treatment Program $10

Visit to Mental Health Professional $15

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

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

Inpatient .....No Copay

Empire Plan Prescription Drugs

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

Generic Drug $5

Brand-Name Drug
with no generic equivalent $15

Brand-Name Drug with a generic equivalent (with some exceptions) .....$15 *plus* difference in cost between brand-name drug and its generic equivalent

Directory of Agency Health Benefits Administrators

This is an alphabetical listing of agencies with employees enrolled through Participating Employers (as of June 2001). Please contact your Health Benefits Administrator when you have questions about the New York State Health Insurance Program or when you are making a change to keep your coverage up to date.

AGENCY	TELEPHONE
Battery Park City Authority	New York (212) 416-5340 Ext. 327
Board of Commission of Pilots of State of New York	New York (212) 425-5027
Bridge Authority	Highland (614) 691-7245
Campus Children's Center	Albany (518) 457-3210
Canal Corp.	Albany (518) 436-2721
Capital District Transit Authority	Albany (518) 482-7286 Ext. 331
Carol A. Dunigan Day Care Center	Albany (518) 447-9663
Children's Center at SUNY Brooklyn	Brooklyn (718) 469-7750
Children's Center at SUNY Purchase	Purchase (914) 251-6895
Children's Corner at Rome	Rome (315) 336-2300 Ext. 570
Cleary Deaf Child Center Inc	Nesconset (631) 588-0530
Clinton Community College	Plattsburgh (518) 562-4137
Criminal Court of the City of New York	New York (212) 374-6263
Dormitory Authority	Albany (518) 257-3543
Empire State Performing Arts Center	Albany (518) 473-1061
Energy Research and Development Authority	Albany (518) 862-1090 Ext. 3241
Environmental Facilities Corporation	Albany (518) 457-4114 Ext. 331
Finger Lakes Independence Center	Ithaca (607) 272-2433
Foster Grandparent Program	Thiells (845) 947-6395
Greenway Conservancy for the Hudson River Valley	Albany (518) 473-3835
Health Research Inc.	Rensselaer (518) 431-1215
Health Research Inc.	Buffalo (716) 845-2325
Horse Breeding Fund	Albany (518) 436-8713
Housing Finance Agency	New York (212) 688-4000 Ext. 223
Housing Trust Fund Corporation	Albany (518) 473-6978
Hudson and Black River Regulating District	Albany (518) 465-3491
Hudson River Park Trust	New York (212) 791-2530

AGENCY	TELEPHONE
Independent Living Center of Hudson Valley	Troy (518) 274-0701
Industrial Exhibit Authority	Syracuse (315) 487-7711
Insurance Department Liquidation Bureau	New York (212) 341-6636
Jacob K. Javits Convention Center	New York (212) 216-2595
Lavelle School for the Blind	Bronx (718) 882-1212
Lexington School for the Deaf	Jackson Heights (718) 350-3033
Long Island Power Authority	Uniondale (516) 719-9823
Long Island Railroad	Jamaica (718) 558-6866
Metro North Commuter Railroad	New York (212) 340-2748
Metropolitan Transportation Authority	New York (212) 878-7370
Mortgage Agency	New York (212) 688-4000 Ext. 623
MTA Bridges & Tunnels	New York (646) 252-7935
MTA Bridges & Tunnels SOBA	New York (646) 252-7936
MTA Long Island Bus	Garden City (516) 542-0100
MTA New York City Transit Authority	Brooklyn (718) 243-3152
Municipal Assistance Corporation	New York (212) 840-8255
Nassau County Interim Finance Authority	Mineola (516) 248-3228
Nathan Kline Institute	Orangeburg (845) 398-5410
National Development and Research Institutes	New York (212) 845-4502
Natural Heritage Trust	Albany (518) 473-6287
New York City Board of Elections	New York (212) 487-5340
New York City Department of Mental Health	New York (212) 219-5251
New York City Housing Development Corporation	New York (212) 227-7405
New York City Probation Division	New York (212) 232-0546
New York Convention Center	New York (212) 216-2595
New York Institute for Special Education	Bronx (718) 519-7000 Ext. 316
New York School for the Deaf	White Plains (914) 949-7310 Ext. 289

AGENCY	TELEPHONE
Palisades Park Commission	Bear Mountain (845) 786-2701 Ext. 216
Potsdam Auxiliary & College Services	Potsdam (315) 267-2147
Purchase College Association	Purchase (914) 251-6962
Regents Research Fund	Albany (518) 486-2423
Research Foundation for Mental Hygiene Inc.	Albany (518) 486-4213
Research Foundation for Mental Hygiene Inc.	New York (212) 543-5338
Roosevelt Island Operation Corporation	Jamaica (718) 558-6866
Roswell Park Day Care Inc.	Buffalo (716) 845-3526
Southern Tier Independence Center	Binghamton (607) 724-2111
St Francis DeSales School	Brooklyn (718) 636-4573
St Joseph's School for the Deaf	Bronx (718) 828-9000 Ext. 244
St Mary's School for the Deaf	Buffalo (716) 834-7200 Ext. 177
State University Construction Fund	Albany (518) 689-2503
Staten Island Rapid Transit Authority	Staten Island (718) 876-8248
Sullivan County Community College	Loch Sheldrake (845) 434-5750 Ext. 4269
Thoroughbred Racing Capital Investment Fund	New York (212) 465-0606
Thruway Authority	Albany (518) 436-2721
Triborough Bridges and Tunnels Authority	New York (646) 252-7935
Ulster County Community College	Stone Ridge (845) 687-5101
Urban Development Corporation	New York (212) 803-3100
Waterfront Commission of New York Harbor	New York (212) 905-9209
Welfare Research Inc.	Albany (518) 432-2576
Westchester Disabled on the Move	Yonkers (914) 968-4717

INDEX

This index lists many, but not all, terms in this book/certificate. The index is provided to help you find the references you need, but the list is not exhaustive. For full information on your health insurance, you must read the complete Book/Certificate.

Notes

Important Telephone Numbers

Empire Plan Benefits Management Program.....1-800-992-1213

- You must call before a maternity or scheduled hospital admission.
- You must call within 48 hours after an emergency or urgent hospital admission.
- You must call before admission or transfer to a skilled nursing facility.
- You must call before having an elective (scheduled) Magnetic Resonance Imaging (MRI).

Following the Benefits Management Program requirements can save you high out-of-pocket costs.

Empire Blue Cross and Blue Shield.....518-367-0009 (Albany area and Alaska)
1-800-342-9815 (NYS and other states except Alaska)

New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407. Call for information regarding hospital and related services.

Centers of Excellence for Transplants Program. You must call Empire Blue Cross and Blue Shield before a hospital admission for the following transplant surgeries: bone marrow, peripheral stem cell, cord blood stem cell, heart, heart-lung, kidney, liver, lung and simultaneous kidney-pancreas. Call for information about Centers of Excellence.

United HealthCare Insurance Company of New York 1-800-942-4640

P.O. Box 1600, Kingston, NY 12402-1600. Call for information on benefits under Basic Medical and Participating Provider Programs, predetermination of benefits, claims and participating providers.

Home Care Advocacy Program (HCAP).....1-800-638-9918

You must call to arrange for paid-in-full home care services and/or durable medical equipment/supplies. If you do not follow HCAP requirements, you will receive a significantly lower level of benefits.

Managed Physical Medicine Program/MPN.....1-800-942-4640

Call for information on benefits and to find MPN network providers for chiropractic treatment and physical therapy. If you do not use MPN network providers you will receive a significantly lower level of benefits.

Infertility Benefits.....1-800-638-9918

You must call for prior authorization for the following Qualified Procedures, regardless of provider: Artificial Insemination; Assisted Reproductive Technology (ART) procedures including in vitro fertilization and embryo placement, Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Intracytoplasmic Sperm Injection (ICSI) for the treatment of male infertility, assisted hatching and microsurgical sperm aspiration and extraction procedures; sperm, egg and/or inseminated egg procurement and processing and banking of sperm and inseminated eggs. Call for information about infertility benefits and Centers of Excellence.

ValueOptions (administrator for GHI).....1-800-446-3995

P.O. Box 778, Troy, New York 12181-0778. You must call ValueOptions before beginning any treatment for mental health or substance abuse, including alcoholism. If you do not follow ValueOptions requirements, you will receive a significantly lower level of benefits. In a life-threatening situation, go to the emergency room. Call within 48 hours.

Empire Plan Prescription Drug Program.....1-800-964-1888

Express Scripts, P.O. Box 1180, Troy, NY 12181-1180. This information does not apply if you have prescription drug coverage through a union Employee Benefit Fund. You must call for prior authorization for BCG Live, Ceredase or Cerezyme, drugs for the treatment of impotency, Enbrel, Epoetin, Human Growth Hormone, Immune Globulin, Lamisil, Prolastin, Pulmozyme or Sporanox.

The Empire Plan NurseLine℠ 1-800-439-3435

Call for health information and advice, 24 hours a day, seven days a week. To listen to the Health Information Library, enter PIN number 335 and a four-digit topic code from the Empire Plan NurseLine brochure.

Teletypewriter (TTY) numbers for callers when using a TTY device because of a hearing or speech disability:

Benefits Management Program.....TTY only: 1-800-962-2208
Empire Blue Cross and Blue Shield .....TTY only: 1-800-241-6894
United HealthCare .....TTY only: 1-888-697-9054
ValueOptions .....TTY only: 1-800-334-1897
Empire Plan Prescription Drug Program .....TTY only: 1-800-840-7879

Agency Health Benefits Administrator *(See Directory on page 136.)* **.....***(fill in)*_____

You must keep your coverage up to date. Call to report that your child, age 19 or over, is no longer a student, to delete a dependent, to add a dependent, to report your address change and to request a replacement card.

COBRA Enrollees: The Employee Benefits Division at **(518) 457-5754 (Albany area) or 1-800-833-4344** serves as your Health Benefits Administrator.

Union Employee Benefit Fund.....*(fill in)*_____

Call your union for prescription drug coverage requirements and other union benefits.

SAVE THIS BOOK

IMPORTANT INFORMATION ABOUT THE NEW YORK STATE HEALTH INSURANCE PROGRAM

This book combines the 1995 *NYSHIP General Information Book and Empire Plan Certificate for Active Employees of Participating Employers* and all *Empire Plan Reports* and amendments updating that book.

Updates to this book will be mailed to you if benefits change. Keep all updates with this book.

Benefit changes that are mailed to you will also be posted on our Web site, http://www.cs.state.ny.us. Click on Employee Benefits.

It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the Employee Benefits Division Web site (http://www.cs.state.ny.us), which meets universal accessibility standards adopted by New York State for NYS Agency Web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA enrollees may call the Employee Benefits Division at (518) 457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands.)

GIB-EP/PE/8-01

Important. Health Insurance Certificate of Insurance For the Enrollee, Enrolled Spouse/Domestic Partner and Other Enrolled Dependents

PRSRT STD
U.S. Postage Paid
Utica, NY
Permit No. 320

State of New York
Department of Civil Service
Employee Benefits Division
The State Campus
Albany, New York 12239
http://www.cs.state.ny.us

Address Service Requested