EIGHTH AMENDMENT
TO
GROUP INSURANCE POLICY NO. 30500-G
IN EFFECT FOR
THE STATE OF NEW YORK

THIS EIGHTH AMENDMENT (the "Amendment") is entered into by the NEW YORK STATE DEPARTMENT OF CIVIL SERVICE ("DCS" or "Department" or "Employer") on behalf of the STATE OF NEW YORK and UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, (the "Insurance Company") referred to collectively as "the Parties".

WHEREAS, the Group Insurance Policy No. 30500-G (the "Policy"), as amended, provides certain agreed upon services and medical and surgical benefits insurance coverage, but not basic hospital insurance nor mental health/substance abuse insurance for Members of certain Employee Groups covered by the Employer; and

WHEREAS, the Parties desire to amend the Policy to discontinue services for the Complementary Alternative Medicine Program; and

WHEREAS, the Parties desire to amend the Policy to change the provision related to retrospective premium payments; and

WHEREAS, the Parties agree that the Policy will renew and the premium rates and performance standards will be amended.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

I. All references to the services and fees for the Complementary Alternative Medicine Program are hereby eliminated from the policy.

II. A. Schedule of Premiums is hereby revoked in its entirety and replaced with new Schedule of Premiums which is attached to this amendment as Exhibit A, and is effective for the period January 1, 2009 through December 31, 2009.

B. Article XXVII, Additional Services, is hereby revoked in its entirety and replaced with new Article XXVII, Additional Services which is attached to this amendment as Exhibit B.

III. Except as expressly amended by this Eighth Amendment, all the terms and conditions of the original Agreement and any amendments thereto shall remain in full force and effect.

IV. This Eighth Amendment shall be deemed effective January 1, 2009.

IN WITNESS WHEREOF, the Parties hereto have hereunder signed this Amendment No. 8 to Policy Number 30500-G on the day and year appearing opposite their respective signatures.

Agency Certification: "In addition to the acceptance of this contract amendment, I also certify that original copies of this signature page will be attached to all exact copies of this contract."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

NANCY G. GROENWEGEN
COMMISSIONER

By: _____

Date: _____

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

Date: _____

By _____

Name: _____

Title _____

STATE OF)
) **ss:**
COUNTY OF)

On the _____ day of _____, _____, before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

_____

NOTARY PUBLIC

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

The following premium rates shall be in effect for the period January 1, 2009 through December 31, 2009:

Premium Rate per Employee					
Employee Group with Plan Changes		Employee Group without Plan Changes		SEHP	
Individual Insurance (Monthly/ Biweekly)	**Family Insurance** (Monthly/ Biweekly)	**Individual Insurance** (Monthly/ Biweekly)	**Family Insurance** (Monthly/ Biweekly)	**Individual Insurance** (Monthly/ Biweekly)	**Family Insurance** (Monthly/ Biweekly)
$150.45/$69.25	$361.06/$166.19	$151.95/$69.94	$364.65/$167.84	$44.50/$20.48	$186.93/$86.04

The Employer shall furnish to the Insurance Company within 3 months after each premium due date a written statement showing the number of Employees insured for Personal Insurance only and the number insured for Personal and Dependent Insurance, as of such due date.

The premium for Employees accounted for on a bi-weekly basis shall be the daily premium rate multiplied by 14. The daily premium rate shall be calculated by multiplying the monthly premium rate by 12 and dividing the product by the number of days in the calendar year for which the premium is in effect.

The renewal action incorporates a retrospective premium payment equal to [redacted] of earned premium in support of the reduction in margin from [redacted]. Specifically, if costs exceed premium as reported in the year end settlement for policy year 2009, an additional payment equal to the lesser of [redacted] of premium or the amount of the loss will be made to UHC. The retro payment, if necessary, will be made by April 15, 2010.

If a loss still exists after payment of this retro payment, the State shall make an additional retro payment if the actual communication expense exceeds the budgeted communication expense of [redacted]. Specifically, an additional premium payment equal to the lesser of the loss (after the first retro

payment) or the amount of communication expense in excess of the budgeted amount will be paid. The amount chargeable to the State Program shall be the actual incurred expenses less the billings to the other carriers. The due date on this second retro premium payment, if applicable, is April 15, 2010.

Under the 5-tier structure for Participating Agencies, the monthly premium rates are as follows:

Premium Rate per Employee				
Plan Prime		MediPrime		
Individual Insurance	**Family Insurance**	**Individual Insurance**	**Family Insurance (1 Medicare Primary)**	**Family Insurance (2 or more Medicare Primary)**
$205.00	$429.29	$68.94	$293.23	$157.17

The Employer guarantees the difference in premiums due to the Insurance Company should the 5-tier rate structure generate less premium than the 2-tier rate structure. Conversely, in the event the 5-tier rate structure generates more premium than the 2-tier structure, the Insurance Company shall return such excess.

Excelsior Plan for the period January 1, 2009 through December 31, 2009, the 2 tier rates are as follows:

- [redacted] per Employee per month for individual insurance
- [redacted] per Employee per month for family insurance

Using historical Participating Agency experience, a factor of [redacted] applied to the combined Core and PA Enhancement premium rates was developed for the Excelsior Plan Medical premium. The rates for 2009 were established using this factor approach.

Under the 5-tier structure for Participating Agencies, the monthly premium rates for the Excelsior Plan are as follows:

Premium Rate per Employee				
Plan Prime		MediPrime		
Individual Insurance	**Family Insurance**	**Individual Insurance**	**Family Insurance (1 Medicare Primary)**	**Family Insurance (2 or more Medicare Primary)**
$237.15	$496.62	$79.75	$339.22	$181.83

The Employer guarantees the difference in premiums due to the Insurance Company should the 5-tier rate structure generate less premium than the 2-tier rate structure. Conversely, in the event the 5-tier

rate structure generates more premium than the 2-tier structure, the Insurance Company shall return such excess.

Uncertainty of actual enrollments and subsequent claim experience for the 2009 policy year requires that the Insurance Company establish parameters for setting the premium using this factor approach. This factor approach will be used to set premiums until this program reaches credibility from both an enrollment and claim history perspective. Credibility is defined as [redacted] or more members consistently enrolled for twelve or more months with a minimum of three months of run-out in order to substantially complete the year. In the event that the overall experience exceeds the [redacted] retro-margin applicable to the 2009 premium rates, the Insurance Company reserves the right to request a separate retro payment on the Excelsior Plan. A retro payment of up to the current two tier Core plus PA Enhancement premium rates plus the [redacted] retro margin due no later than March 31, 2010.

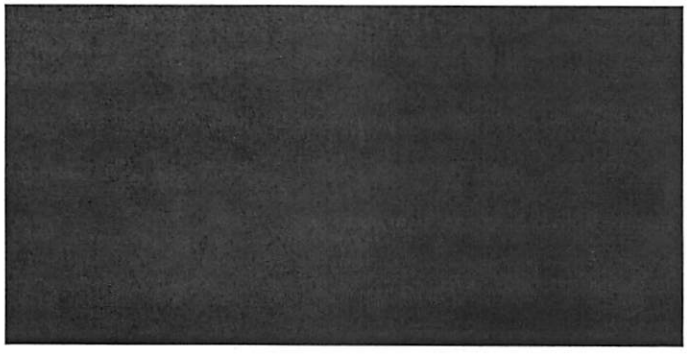
Included in the premium rates are the following administrative costs of the Additional Services provided under the Group Policy for the period January 1, 2009 through December 31, 2009 unless indicated otherwise. With the exception of Communication Support Services, the following administrative fees include the Insurance Company's [redacted]:

1. **Managed Physical Medicine Program**
   - [redacted] per Member per month

   The cost for this program is applicable to all Empire Plan Members. "Members" means Employees and Dependents covered by the Plan

2. **Empire Plan NurseLine$_{SM}$ Program**

   With the implementation of the integrated Disease Management Program on March 1, 2007, [redacted]



[redacted]

[redacted]

Fees used in the development of premium rates shall be based on the preceding 12 months of utilization ending on March 1st of each year.

The cost for this program is applicable only to Members of certain Employee Groups designated by DCS for which the benefit has been collectively bargained or administratively extended.

3. **Disease Management Program**
   - [redacted] per Member per month effective March 1, 2008
   - [redacted] per Member per month effective March 1, 2009

   The cost for this program is applicable to Empire Plan Primary Members [redacted] for which the benefit has been collectively bargained or administratively extended.

4. **Network Integration**
   - [redacted] per Employee residing in the integrated states per month (excluding directory printing).

   The standard access fee for this program is derived from the monthly enrollment (contracts) in the integrated states, [redacted] market beginning on March 1, 2008, times the monthly fee. Directory printing costs are not included in this premium rate and will be charged to the plan as produced on a cost plus basis with an [redacted] added.

5. **Benefits Management Program including Prospective Procedure Review for elective Magnetic Resonance Imaging (MRI), Voluntary Specialist Consultant Evaluation and Voluntary Medical Case Management**

   The administrative cost for these services shall be based on the actual cost incurred by the Insurance Company.

   Prospective Procedure Review effective July 1, 2008
   - [redacted] per transaction or [redacted] per Member per month (vendor fees are [redacted] per transaction, not to exceed [redacted] per Member per month) for MRA, CT, PET and Nuclear Medicine (including Nuclear Cardiology) procedures. Comparison and reconciliation of

per Member per month vs. per transaction fees are to be performed annually on each July 1st.

- [redacted] per transaction or [redacted] per Member per month (vendor fees are [redacted] per transaction, not to exceed [redacted] per Member per month) for MRI procedures. Comparison and reconciliation of per Member per month vs. per transaction fees are to be performed annually on each July 1st.

6. **Consolidated Toll-Free Service**
   - [redacted] per Employee per month for operational oversight, technological coordination and monthly reporting on call volume and trends.
   - Charges for script storage, script usage, transfer connect, and toll-free usage are [redacted]

7. **Basic Medical Provider Discount Program** effective October 1, 2004

   A) [redacted] BMPDP fees are subject to review and approval of the Department.

   B) [redacted]

8. **Cancer Resource Services** effective October 1, 2004
   - [redacted] per employee per month effective with the groups bargained or administratively extended effective date.

9. **Drug Rebates** effective January 1, 2004

[redacted] of the Drug Rebates the Insurance Company receives in connection with prescription drug products dispensed to Members under the Plan's medical benefit. (The remaining [redacted] of the rebates are to be retained by the Employer.)

10. **Prosthetic and Orthotic Provider Network**
    - [redacted] per Member per month for Non-Medicare primary members who reside in New York State and for which the benefit has been collectively bargained or administratively extended.

11. **Communication Support Services**

Budgeted amount to be allocated for the 2009 calendar year is as communicated by the Employer in the annual rate approval letter to the Insurance Company.

12. **Workers Compensation Recovery Program** effective April 1, 2007
    - [redacted] of gross recoveries made resulting from this program.

13. **Outpatient Surgical Facility Claims Services** effective August 1, 2007
    - [redacted] per month for the repricing of claims for outpatient surgical facility fees.

14. **Kidney Resource Services (KRS) Program** (Excludes SEHP Members) effective July 1, 2008
    - [redacted] per Member per month

The cost for this program is applicable to Empire Plan Primary Members (excludes SEHP) for which the benefit has been collectively bargained or administratively extended.

15. **Taxes Assessments & Surcharges**

- ***Taxes:*** Premium tax is [redacted] of the amount up to the total of all claims, reserves, claim and administrative costs, other retention, but is subject to change, during the term of the Agreement if the rate as determined by governmental/regulatory agencies changes.
- ***New York State Insurance Department Assessment:*** New York State Insurance Department Assessment shall be charged using the imputed percentage based on the assessment levied by the Department of Insurance; the imputed percentage will be applied to total of all claims, reserves, claim and administrative costs and other retention. The assessment is subject to change, during the term of the Agreement if the rate determined by

governmental/regulatory agencies changes. The final assessment will be reconciled and charged based on the final assessment levied by the New York State Insurance Department.

- ***Metropolitan Transportation Business Tax Surcharge (MTA Surcharge):*** Transportation Business Tax Surcharge shall be [redacted] of the premium tax rate applied to the premium for enrollees residing in the Metropolitan Commuter Transportation District (MCTD). The surcharge is subject to change, during the term of the Agreement if the rate as determined by governmental/regulatory agencies changes.
- ***New federal or state tax, assessment or surcharge:*** as implemented during the term of the Agreement at the rate determined by governmental and regulatory agencies.

16. **Other Charges/Credits**

- ***Expense Load:*** The Insurance Company will apply an incremental [redacted] to the Insurance Company's portion of Communication Support Services and all administrative expenses except for those listed in Article XXVII - Additional Services Exhibit C of this amendment.
- ***Risk Charge:*** The Risk Charge for policy year 2009 is calculated annually as final earned premium less the experience gain/(loss) , as displayed in the final financial statement, multiplied by [redacted].

ARTICLE XXVII. ADDITIONAL SERVICES

In addition to the insurance provided by this Policy, the Insurance Company shall provide the following additional services beginning as of an effective date agreed to by the Employer and the Insurance Company, for the employee groups designated by the Employer.

The cost for these additional services are included in the premium rates agreed to by the parties:

1. **Managed Physical Medicine Program** (as implemented on August 1995)

   For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company will provide access to a Managed Physical Medicine Program ("Program").

   A Managed Care Network will be made available to Employees and their Dependents, located in those geographical sites agreed to by the Parties. The Network shall include Providers who render chiropractic treatment, physical and occupational therapies. These Network Providers will be included in a directory of providers with periodic updates and/or telephonic access to the information in the directories.

   The contracted health care providers participating in the Managed Care Network can change at any time. Notice on changes will be given in advance or as soon as reasonably possible.

   The Insurance Company will maintain a grievance process so that Members may obtain assistance with, and express their opinions about, their use of the Managed Care Network.

   The Insurance Company does not employ Network Providers and they are not the Insurance Company's agents or partners. Network Providers participate in Managed Care Networks only as independent contractors. Network Providers and the Members are solely responsible for any health care services rendered to Members that are not covered under the benefits provided by the Insurance Company.

2. **Empire Plan NurseLine$_{SM}$ Program** (as implemented on February 1, 2000).

   For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company will provide Participants with communication materials as mutually agreed upon by the Employer and the Insurance Company, and Empire Plan NurseLine$_{SM}$, a 24-hour, seven (7) days per week service providing general health information, the identification of specific health related concerns, direct the caller to the right setting to meet their health concern as well as education information regarding those concerns, by registered nurses by telephone or via an audio health information library.

3. **Disease Management Program** (as implemented on dates indicated)

   For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company shall offer agreed upon Program services to Members. The Insurance Company will provide access to various Disease Management Programs to the Employee groups designated by the Employer.

The parties agree that the Insurance Company will not disclose to the Employer, the Employer's auditors, or other third parties, the unencrypted identity of Members enrolling in the Program without the Member's written consent.

From claims data received, the Insurance Company will determine those Members who may benefit from the Program. The Insurance Company shall extend invitations to all eligible Members who meet program criteria and may benefit from the Program and shall offer the Members the opportunity to participate in the Program.

As Implemented on March 1, 2007, the Insurance Company will provide an Integrated Disease Management Program for the conditions of diabetes, asthma, cardiovascular/coronary artery disease, heart failure, and chronic obstructive pulmonary disease independently or through a third party contracted entity or affiliate as proposed by the Insurance Company and approved by DCS. This Integrated Disease Management Program will replace all Disease Management programs previously provided.

The Insurance Company can terminate the disease management services in whole or in part at any time, after providing the Department at least ninety (90) days prior written notice of such termination, for any reason if such termination applies to all of its similarly situated customers. After the [redacted] months of disease management services under this Agreement, the Employer may terminate the disease management services with [redacted] days prior written notice.

Additional disease management program may be made available upon agreement by the Parties.

4. **Network Integration Program** (as implemented on January 1, 1999 for [redacted] and July 1, 2000 for [redacted] and March 1, 2008 for the [redacted])
For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company will make available to the Employer access to agreed upon UnitedHealthcare PPO Networks outside the State of New York. The Insurance Company will conduct an analysis periodically and make recommendations to the Employer regarding which states could realize improved participating provider access for Employees and Dependents residing or traveling outside the State of New York if the UnitedHealthcare PPO Network were made available. If the Employer and the Insurance Company agree to add a PPO network in a state or market, the Insurance Company will take a reasonable time to implement appropriate system changes, effectively communicate any changes to Employees, Dependents and the participating providers and conduct any training necessary for the customer and provider relations staff.

5. **Benefit Management Program** (as implemented on January 1, 2002 and expanded Prospective Procedure Review on July 1, 2008)

The Insurance Company will provide various Benefit Management Programs administered by the Insurance Company to the Employer Groups designated by the Employer. Benefit Management Programs include: Prospective Procedure Review, Voluntary Medical Case Management, and Voluntary Specialist Consultant Evaluation.

For services that require Prospective Procedure Review, the Insurance Company will review submitted medical information and compare to nationally accepted medical criteria to determine the appropriateness of the procedure. The Insurance Company will refer services that initially fall outside of the medical criteria to a board certified practicing physician for

additional review. The Insurance Company will notify enrollees, in writing, of the outcome of the Prospective Procedure Review within [redacted] business days of receipt of all information needed to complete the review.

The Insurance Company will identify through claims analysis and consultation with the Hospital Program Insurer, members who may benefit from Medical Case Management. The Insurance Company will offer voluntary participation in the Program to members meeting the criteria. For members who agree to participate in the Program, and in consultation with the treating physician, the Insurance Company will develop and implement a treatment plan which may include home care covered under HCAP, physicial therapy covered under the MPMP, as well as alternate benefits for services/care which are not covered under the Empire Plan benefit design, unless authorized as part of an MCM case.

The Insurance Company will provide members who contact them regarding a Voluntary Specialist Consultation Evaluation with a list of up to three physicians whose specialty is similar to the treating physician.

The Prospective Procedure Review program is added effective July 1, 2008 to expand pre-notifications to include those for MRI, MRA, CT, PET and Nuclear Medicine (including Nuclear Cardiology) procedures for eligible members.

6. **Consolidated Toll Free Services** (as implemented on November 1, 2002)

   For the cost shown in the Schedule of Premiums, the Insurance Company will provide a toll-free service for Empire Plan members consolidating toll-free telephone numbers for multiple benefit insurers associated with the Empire Plan. The Insurance Company will act as liaison with each of the Empire Plan insurers for implementation, operational oversight, and technological coordination for these services and will provide standard monthly call volume and trend reports to the Employer.

7. **Basic Medical Provider Discount Program** (Program effective October 1, 2004)

   The Insurance Company shall make its Physician's Shared Savings Program available to the Employee Groups designated by the Department as eligible for the Empire Plan Basic Medical Provider Discount Program (BMPDP). The BMPDP provides access to discounted charges made available to the Insurance Company from health care providers who contract with a third party to provide such discounted charges when the discounted charges are less than the reasonable and customary value of the claim under the Basic Medical Program. The services under the BMPDP provide access to provider discounts only. These providers do not constitute a network

   If a Member is enrolled in the Empire Plan and receives services from an Empire Plan Network Provider on the date services were rendered or the provider was an Empire Plan Network Provider within two years imediately preceeding the date services were rendered, the BMPDP and any related fees shall not be applicable. In addition, the Department will not pay any fee for misprocessed or ineligible claims.

   Furthermore, in no case will the Department pay, on any claim, any portion of a fee that when added to the BMPDP allowed amount, would cause the Empire Plan to incur a higher cost than would have been incurred under the Basic Medical Program.

The Insurance Company can terminate all or part of the BMPDP at any time for any reason if such termination applies to all of its similar situated customers with a least [redacted] days written notice to the Department prior to termination of the BMPDP. The Department can terminate the program at any time for any reason by giving the Insurance Company [redacted] days written notice. The Insurance Company will implement the termination on the [redacted] day after receiving such notice.

8. **Cancer Resource Services** (Program effective October 1, 2004 and effective April 23, 2007 the program is expanded to include bone marrow transplants)

   The Insurance Company agrees to provide to the Employee Groups designated by the Employer a network of providers for Oncology Services. The term "Oncology Services" as used in this section includes health care services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology. Oncology Services rendered by these providers, and the discounted rates for these services, are available to Members based on the contractual relationship between the Insurance Company's affiliate, OptumHealth/United Resource Networks, and these providers.

   The Plan will pay for and cover as Plan benefits Oncology Services, which includes supplies and a lifetime travel allowance, in accordance with the collective bargaining agreement in effect for each Employee Group.

9. **Drug Rebates** (Program effective January 1,2004)
   The Insurance Company or an intermediary may negotiate with drug manufacturers regarding the payment of Drug Rebates on applicable prescription drug products dispensed to Members under the Plan's medical benefit starting with July 1, 2003.

   The Employer will receive [redacted] of the Drug Rebates the Insurance Company receives in connection with prescription drug products dispensed to Members under the Plan's medical benefit. The Insurance Company will retain the balance of such Drug Rebates as part of its compensation under this Agreement. If an intermediary is involved, it may retain a portion of the gross amounts received from drug manufacturers in connection with the relevant prescription drug products dispensed to Members under the Plan's medical benefit.

   The Employer will only receive Drug Rebates to the extent that Drug Rebates are actually received by the Insurance Company. Thus, for example, if a government action or a major change in pharmaceutical industry practices prevents the Insurance Company from receiving Drug Rebates, the amount the Employer receives may be reduced or eliminated.

   The Employer agrees that during the term of this Agreement, neither the Employer nor the Plan will negotiate or arrange or contract in any way for Drug Rebates or the purchase of prescription drug products from any manufacturer under the Plan's medical benefit under this Agreement.

10. **Prosthetic and Orthotic Provider Network** (Program effective January 1, 2005)

    The Insurance Company agrees to develop and maintain a network of prosthetic and orthotic providers.

11. **Communication Support Services** (Program effective January 1, 2005)
The Insurance Company agrees to facilitate the payment of invoices related to the Department's Communication Budget as directed by the Department. DCS will provide the Insurance Company a schedule of the annual Communications Budget including amounts to be collected on a quarterly basis by the Insurance Company from other carriers of the Plan. Amounts collected from other carriers will be treated as an offset to the total communications expense and [redacted] will be applied to the net communications expense. Any invoices received after January 31 of the current year which pertain to the previous years Communications Budget, will be applied to the current years budget. The Insurance Company agrees to provide DCS a report of invoices paid in relation to budgeted amounts each quarter for their review.

12. **Workers Compensation Recovery Program** (Program effective April 1, 2007)

The Insurance Company will provide recovery services for overpayments related to Workers Compensation (WC) claims through its recovery vendor. Recovery services on claims for Participating Agencies (PA's), Participating Employers (PE's) and spouses and dependents age 16 years or older of New York State (NY) enrollees will be provided and any overpayments will be collected directly from the WC carriers. Recoveries will not involve contact with members or providers and will not apply to claims for active New York State employees. The Employer will not engage any other entity to provide the services described herein without the Insurance Company's prior approval.

Fees will be charged as a [redacted] deducted from the actual recoveries with the net amount of the recovery credited back to the Employer. An advance notice will be provided if there are any changes in the fees for these recovery services.

The Insurance Company has the authority to develop and use, after Department review and approval, standards and procedures for any recovery, including but not limited to, whether or not to seek recovery, what steps to take if it is decided to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. The use of Insurance Company standards and procedures may not result in full or partial recovery for any particular case. A recovery will not be pursued if it is not permitted by any applicable law, or if recovery would be impractical. Litigation may be initiated to recover payments, but there is no obligation to do so.

13. **Outpatient Surgical Facility Claims Services** (Program effective August 1, 2007)

The Insurance Company will use established reasonable and customary values from a source approved by DCS for outpatient surgical facility claims covered under the Basic Medical Program.

14. **Kidney Resource Services (KRS) Program** (Program effective July 1, 2008)
The Insurance Company will provide a Kidney Resource Services program to eligible Members. The program will include members with End Stage Renal Disease and Stages 5, 4 and 3 kidney disease who opt to participate.