



GENERAL INFORMATION & BOOK EMPIRE PLAN CERTIFICATE AMENDMENTS

For Employees of the State of New York
represented by **Council 82**
*who are subject to the binding arbitration
award issued on September 8, 2006*
and for their enrolled Dependents
and for COBRA enrollees with their benefits

JANUARY 2007

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

**Keep these amendments with
your July 1, 2003 New York State
Health Insurance Program
General Information Book and
Empire Plan Certificate for
Employees of the State of New
York represented by Council 82.**
Pages in your Book/Certificate and
later Certificate Amendments have
consecutive numbers.

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

Where this document differs from your July 1, 2003 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports and Certificate Amendments*, this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Add the following as the fifth bullet under “Changing options outside the Option Transfer Period” in the “Your Options Under NYSHIP” section on page 3 of your NYSHIP General Information Book.

Changing options

- You add a new dependent to your coverage. The dependent may be acquired through marriage, domestic partnership, birth, adoption or placement for adoption.

Substitute the following for the third sentence of the first paragraph of “Or your domestic partner” under “Your dependents” in the “Who is Eligible?” section on page 4 of your NYSHIP General Information Book.

Domestic partner

Effective January 1, 2007. To enroll a domestic partner, you must have been in the partnership for six months and be able to provide proof of residency and financial interdependence.

Substitute the following for the fifth paragraph of “Or your domestic partner” under “Your dependents” in the “Who is Eligible?” section on page 5 of your NYSHIP General Information Book.

Effective January 1, 2007. There will be a one-year waiting period from the termination date of your previous partner’s coverage before you may again enroll a domestic partner.

Substitute “Empire Plan Benefit Card” wherever “New York Government Employee Benefit Card” appears in your NYSHIP General Information Book and Empire Plan Certificate.

Substitute the following for the fifth and sixth bullets under “When your Family coverage begins” in the “Coverage: Individual or Family” section on page 10 of your NYSHIP General Information Book.

Family coverage

- If you apply **more than 7 days but within 30 days after** the event, there will be a waiting period. Your Family coverage will become effective on the day you apply if you apply on the first day of a payroll period. Otherwise, it will begin on the first day of the next payroll period.
- 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 fifth payroll period following the payroll period in which you apply.

Substitute the following for the fourth, fifth and sixth paragraphs in the box entitled “Changing to Family Coverage” in the “Coverage: Individual or Family” section on page 11 of your NYSHIP General Information Book.

If you apply more than 7 days but within 30 days after the event, coverage begins on the first day of the next payroll period.

If you apply more than 30 days after the birth or adoption of a newborn or any other event, coverage begins on the first day of the fifth payroll period.

Exception for court order

Substitute the following for “Exception for court order” in the “Coverage: Individual or Family” section on page 10 of your NYSHIP General Information Book.

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

Identification card

Substitute the following for the first paragraph, “Your card” and the second paragraph “Separate card for each dependent” under “Identification Cards” on page 11 of your NYSHIP General Information Book.

Your Empire Plan Benefit Card is a plastic card similar to a bank or credit card. You will receive your Empire Plan Benefit Card after your enrollment in The Empire Plan is processed.

Substitute the following for the bordered section, “Sample New York Government Employee Benefit Card for Empire Plan Enrollees” on page 12 of your NYSHIP General Information Book.

Sample Empire Plan Benefit Card for Empire Plan Enrollees



The nine digits are your alternate Identification Number.

The Blue Cross Blue Shield Inter-Plan Bank Code is YLS. Out-of-State hospital claims submitted with this code will reach the correct Blue Cross and/or Blue Shield plan.

IRS regulations

Substitute the following for the first sentence of “Changes permitted only after certain events” under “Costs, Pre-Tax Program and What Your Paycheck Stub Shows” on page 14 of your NYSHIP General Information Book.

Under the Internal Revenue Service (IRS) rules, you may change your health insurance deduction during the plan year only after one of the following PTCP-qualifying events:

Substitute the following for “IRS regulations: Arbitrary changes not permitted during the year” under “Costs, Pre-Tax Program and What Your Paycheck Stub Shows” on page 14 of your NYSHIP General Information Book.

IRS regulations:

Changes in benefit elections during the plan year that do not stem from a qualifying event are not permitted by the IRS and cannot change the amount of your pre-tax health insurance deduction.

Since IRS regulations restrict changes in your benefit elections and their related health insurance premium deductions during a plan year, NYSHIP enrollees who are enrolled in the PTCP are not permitted to make the following two changes during the plan year:

- You may not change from Family to Individual coverage while your dependents are still eligible for coverage unless the change stems from a qualifying event.
- You may not voluntarily cancel your coverage while you are still eligible for coverage unless the change stems from a qualifying event.

These limitations apply only to changes made during the plan year when there is no PTCP-qualifying event.

THE EMPIRE PLAN BENEFITS MANAGEMENT PROGRAM

Substitute the following for “If you do not follow the pre-admission certification requirements” on pages 44-45 of The Empire Plan Benefits Management Program.

Pre-admission certification

Effective January 1, 2007. If you do not follow the pre-admission certification requirements:

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

or

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

or

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

- a \$200 hospital deductible if it is determined that any portion of your hospitalization was medically necessary
- and
- **Effective January 1, 2007**, you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

You may appeal any penalty imposed for failure to call within 48 hours, if you did not call within the required 48 hours after an emergency or urgent hospital admission due to circumstances beyond your control (for example, due to your illness), but did call as soon as was reasonably possible.

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

Substitute the following for the last sentence of the first paragraph and the first two bulleted paragraphs of “There are penalties for not complying with the Prospective Procedure Review requirements” in the “Prospective Procedure Review: MRI” section on pages 46-47 of The Empire Plan Benefits Management Program.

Prospective procedure review: MRI

Effective January 1, 2007. If you fail to call and the Empire BlueCross BlueShield and/or United HealthCare review confirms that the MRI was medically necessary but not an emergency, you will be responsible for paying the following:

- When the MRI is performed in the outpatient department of a hospital, you are liable for the payment of the lesser of 50 percent of the covered

hospital charge or \$250. You will also be responsible for the applicable outpatient hospital copayment or coinsurance.

- When the provider(s) administering and/or interpreting the MRI is an Empire Plan participating provider under the Medical Program, you are liable for the payment of the lesser of 50 percent of the scheduled amounts or \$250. You will also be responsible for the \$15 copayment.

EMPIRE BLUECROSS BLUESHIELD CERTIFICATE OF INSURANCE

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

Network and non-network facilities

Effective January 1, 2007. Network hospitals and facilities means hospitals and facilities that participate in the BlueCross and BlueShield Association Blue Card PPO® Program through local BlueCross and/or BlueShield plans. When you use network hospitals and facilities, covered services are paid in full subject to the Benefits Management Program requirements and except for any applicable copayments that you pay.

Non-network hospitals and facilities means hospitals and facilities that do not participate in the BlueCross and BlueShield Association Blue Card PPO® Program network. When you use non-network hospitals and facilities, you must pay a higher share of the cost of covered services. Network benefits may apply at non-network facilities under certain circumstances (see "Network and non-network benefits").

Substitute the following for "If you do not follow the provisions of the Benefits Management Program" under "Hospital admission" in the "Benefits Management Program" section on page 51 of your Empire BlueCross BlueShield Certificate.

Hospital admission

Effective January 1, 2007. If you do not follow the provisions of the Benefits Management Program, Empire BlueCross BlueShield will still review your claim and will apply the following deductibles and copayments:

- If you did not call the Benefits Management Program for Pre-Admission Certification of an elective (scheduled) inpatient admission or an admission for the birth of a child, Empire BlueCross BlueShield will apply a \$200 hospital deductible. Effective January 1, 2007, no payment will be made for any day during which it was not medically necessary for you to be an inpatient.
- If you called the Benefits Management Program and did not receive certification for your admission and you are admitted to the hospital as an inpatient, you will be responsible for all charges for each day it was not medically necessary for you to be an inpatient. If only a part of your inpatient stay was certified, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.
- If you did not call the Benefits Management Program within 48 hours after an emergency or urgent hospital admission, Empire BlueCross BlueShield will apply a \$200 hospital deductible. In addition, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

You may appeal the penalty imposed for failure to call within 48 hours, if you did not call within the required 48 hours after an emergency or urgent hospital admission due to circumstances beyond your control (for example, due to your illness), but did call as soon as was reasonably possible.

- If it is determined that you followed the procedures for emergency or urgent admission when you should have followed the Pre-Admission Certification procedures for an elective (scheduled) admission or admission for the birth of a child, Empire BlueCross BlueShield will apply a \$200 hospital deductible. In addition, you will be responsible for all charges for each day on which it was not medically necessary for you to be an inpatient.

Substitute the following for the last two sentences of “Outpatient MRI” in the “Benefits Management Program” section on page 52 of your Empire BlueCross BlueShield Certificate.

Outpatient MRI

Effective January 1, 2007. If you fail to call the Benefits Management Program and Empire BlueCross BlueShield’s review confirms that your procedure was medically necessary, but not an emergency, you will be responsible for paying the lesser of 50 percent of the covered hospital charge or \$250. The applicable hospital outpatient copayment or coinsurance will be applied to the remaining covered charge.

Insert the following before “Inpatient Hospital Care” on page 52 of your Empire BlueCross BlueShield Certificate.

Network and Non-Network Benefits

Network and non-network benefits

Effective January 1, 2007. The following applies to enrollees who have primary coverage through The Empire Plan.

There are two levels of benefits under the Hospital Program – Network and Non-network.

1. Network benefits: When you use a network hospital, skilled nursing facility or hospice care facility, inpatient and outpatient covered services are paid in full except for:
 - A. any applicable hospital outpatient copayments; and
 - B. any hospital deductibles or coinsurance amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.
2. Non-network benefits: When you use a non-network hospital, skilled nursing facility or hospice care facility, you are responsible for a larger share of the cost of covered services, unless the criteria listed in section 3, below, apply. You are responsible for:
 - A. 10 percent of the billed charges for inpatient hospital, skilled nursing facility or hospice care facility services up to the coinsurance maximum;
 - B. 10 percent of the billed charges or a \$75 copayment for hospital outpatient services, whichever is greater, up to the coinsurance maximum.

The **annual coinsurance maximum** for covered inpatient/outpatient services received at a non-network hospital and covered inpatient services received at a non-network skilled nursing facility or hospice care facility is \$1,500 for the enrollee, \$1,500 for the enrolled spouse/domestic partner, and \$1,500 for all dependent children combined. After the maximum levels have been reached, inpatient services are paid in full, hospital emergency room visits are subject to a \$50 copayment, hospital outpatient services are subject to a \$35 copayment and physical therapy services are subject to a \$15 copayment. Once you have paid \$500 in non-network coinsurance, amounts in excess of \$500 are reimbursable under the Basic Medical Program (see page 174 of these Empire Plan Amendments).

Non-network coinsurance and copayment amounts apply in addition to any deductible and coinsurance amounts that are your responsibility because of your failure to meet the requirements of the Benefits Management Program.

3. Network benefits at a non-network hospital/facility: If you use non-network hospitals and facilities you will receive network benefits for covered services:
 - A. When no network facility is available within 30 miles of your residence;
 - B. When no network facility within 30 miles of your residence can provide the covered services you require;
 - C. When the admission is deemed by Empire BlueCross BlueShield as an emergency or urgent inpatient or outpatient admission;
 - D. When care is received outside the United States;
 - E. When another insurer, including Medicare is providing primary coverage.

The Empire Plan BlueCross BlueShield payment for medically necessary covered services received in a non-network hospital is made directly to you. You pay any applicable outpatient copayment at the network level and any deductibles or coinsurance amounts that apply because of your failure to follow the requirements of the Benefits Management Program. You are responsible for making the payment to the non-network hospital.

Empire Plan network hospitals, hospices and skilled nursing facilities are listed on the New York State Department of Civil Service web site at www.cs.state.ny.us. Click on Benefit Programs, then on NYSHIP Online. Select your group and then click on Find a Provider. You can also call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire BlueCross BlueShield.

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

Inpatient hospital care

Effective January 1, 2007. Empire BlueCross BlueShield will usually pay, subject to network and non-network benefit levels, for all the diagnostic and therapeutic services provided by the hospital.

Substitute the following for the thirteenth bullet, "Chemotherapy" under "2. Hospital services covered." in the "Inpatient Hospital Care" section on page 52 of the Empire BlueCross BlueShield Certificate.

- Chemotherapy except if you are enrolled in the United HealthCare Centers of Excellence Program and receiving care at a Cancer Resource Services network facility.

Substitute the following for the first paragraph of the "Outpatient Hospital Care" section on page 53 of your Empire BlueCross BlueShield Certificate as amended in your January 2004 Empire Plan Report.

Outpatient hospital care

Effective January 1, 2007. When you receive the services described in the following sections and subject to the limitations in those sections, Empire BlueCross BlueShield will pay for the same services provided to you in the outpatient department of a hospital as Empire BlueCross BlueShield pays when you are an inpatient in a hospital as described on page 52 under "Inpatient Hospital Care." This coverage also applies to services provided at a hospital extension clinic (a remote location including ambulatory surgical centers) owned and operated by the hospital. As in the case of inpatient care,

the service must be given by an employee or an agent of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service.

Substitute the following for the second paragraph under “5. Physical therapy.” in the “Outpatient Hospital Care” section on page 54 of your Empire BlueCross BlueShield Certificate.

Physical therapy

Effective January 1, 2007. You pay a \$15 copayment for each visit to the outpatient department of a network hospital or the greater of 10 percent of charges or \$75 at a non-network hospital for physical therapy when covered by Empire BlueCross BlueShield. This payment is in addition to any other payment, either copayment or coinsurance, applied to outpatient services rendered on the same day.

Substitute the following for the first sentence of “7. Chemotherapy.” in the “Outpatient Hospital Care” section on page 54 of your Empire BlueCross BlueShield Certificate.

Chemotherapy

7. Chemotherapy. Empire BlueCross BlueShield pays for chemotherapy, except if you are enrolled in the United HealthCare Centers of Excellence Program and receiving care at a Cancer Resource Services network facility.

Substitute the following for “\$35 copayment for emergency care” in the “Outpatient Hospital Care” section on page 54 of your Empire BlueCross BlueShield Certificate.

Copayment for emergency care

Effective January 1, 2007. You must pay the first \$50 in charges (copayment) for emergency care in a hospital emergency room. See page 53, “Outpatient Hospital Care,” for emergency care. Hospitals may require payment of this charge at the time of service.

The \$50 emergency room copayment covers use of the facility for **emergency care** and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services. Refer to your United HealthCare Certificate, page 83, “What is Covered Under the Basic Medical Program (non-participating providers),” if you receive bills for hospital emergency room service from these providers.

You will not have to pay this \$50 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for “\$25 copayment for outpatient hospital services” in the “Outpatient Hospital Care” section on page 55 of your Empire BlueCross BlueShield Certificate.

Copayment for outpatient hospital services

Effective January 1, 2007. You must pay the first \$35 in charges (copayment) for each visit to a network facility or the greater of 10 percent of charges or \$75 at a non-network facility where you receive one or more of the following covered hospital outpatient services, and hospitals may require payment of this charge at the time of service:

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

Only one copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The \$35 copayment covers the outpatient facility.

You will not have to pay this \$35 facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you at that time as an inpatient.

There is no copayment for the following covered hospital outpatient services provided at a network facility:

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

When the above services are provided at a non-network facility, you must pay the greater of 10 percent of charges or \$75.

Substitute the following for “A.” and “B.” under “2. Kind of skilled nursing facility.” in the “Skilled Nursing Facility Care” section on page 55 of your Empire BlueCross BlueShield Certificate.

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

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

Effective January 1, 2007, coverage is subject to the network and non-network level of benefits.

Substitute the following for “1. Hospice organizations.” in the “Hospice Care” section on page 56 of your Empire BlueCross BlueShield Certificate.

1. Hospice organizations. Empire BlueCross BlueShield will pay for hospice care provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided.

Effective January 1, 2007, coverage is subject to the network and non-network level of benefits.

Substitute the following for the second paragraph under “What is covered” in the “Centers of Excellence for Transplants Program” section on page 57 of your Empire BlueCross BlueShield Certificate.

When the above services are pre-authorized by Empire BlueCross BlueShield and provided at a Center of Excellence for Transplants facility, you will not have to make any copayments, and a travel, 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. When the facility is more than 200 miles from the recipient’s home, available coach airfare is covered.

Substitute the following for the paragraph “Other benefits still available” in the “Centers of Excellence for Transplants Program” section on page 57 of your Empire BlueCross BlueShield Certificate.

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 BlueCross BlueShield for pre-admission certification of admissions for any transplants.

Skilled nursing facility

Hospice care

Transplants Program

Other benefits

Substitute the following for the second paragraph of “Infertility Benefits” and for “Maximum lifetime benefit” in the “Infertility Benefits” section on page 57 of your Empire BlueCross BlueShield Certificate.

Infertility benefits

Effective January 1, 2007. Infertility benefits, including Qualified Procedures (see below), are subject to the same copayments and deductibles as benefits for other medical conditions under the hospital program. Qualified Procedures are subject to a \$50,000 lifetime maximum.

Benefits paid for Qualified Procedures under The Empire Plan are subject to a lifetime maximum of \$50,000 per covered individual. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures.

UNITED HEALTHCARE CERTIFICATE OF INSURANCE

Substitute the following for “Note” in the “Plan Overview” section on page 74 of your United HealthCare Certificate.

Plan overview

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

\$15 copayment

Effective January 1, 2007. Substitute “\$15 copayment” for “\$10 copayment” wherever the \$10 appears in your United HealthCare Certificate.

Substitute the following for “Hospital admission” on page 75 of your United HealthCare Certificate.

Hospital admission

Effective January 1, 2007. If you have a hospital admission which is covered under this Plan, you must comply with the **Pre-Admission Certification** requirements. If you do not comply, you will be subject to paying a \$200 inpatient deductible if any portion of the hospitalization is determined to be medically necessary. **Effective January 1, 2007,** you will be responsible for all charges for any day it is determined that your hospitalization is not medically necessary.

Coinsurance maximum

Substitute “\$1,241 for calendar year 2007” in the first and second paragraphs of “T. 2. b. The covered percentage” under “Meaning of Terms Used” on page 78 of your United HealthCare Certificate.

Substitute the following for the third paragraph of “T. 2. b.” of “Meaning of Terms Used” on page 79 of your United HealthCare Certificate.

However, the annual deductible does not count toward the coinsurance maximum. Any expenses above the reasonable and customary charge do not count. Your expenses under the Managed Physical Medicine Program, Mental Health and Substance Abuse Program and Empire BlueCross BlueShield Hospital Program do not count, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program. Any reimbursement for non-network hospital out-of-pocket expenses does not count.

Substitute the following for “U. Outpatient” in the “Meaning of Terms Used” section on page 79 of your United HealthCare Certificate.

Outpatient

U. Effective January 1, 2007. Outpatient means that covered medical expenses are incurred in a doctor’s office, in the outpatient department of a hospital or in a hospital extension clinic (a hospital owned and operated remote location including an ambulatory facility).

Infertility benefits maximum

Substitute the following for the third sentence of “Infertility Benefits requirements apply...” on page 76 and the second sentence of “X. The Lifetime Maximum” under “Meaning of Terms Used” on page 79 of your United HealthCare Certificate.

Effective January 1, 2007. The Lifetime Maximum for authorized Qualified Procedures for infertility treatment is \$50,000 per covered person under The Empire Plan hospital and medical programs.

Add the following as the last sentence of “Adult Immunizations” under “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 81 of your United HealthCare Certificate as amended in your September 2005 Amendments.

HPV immunization

Effective June 29, 2006. Female enrollees and dependents age 19 through 26 years pay a copayment for human papilloma virus (HPV) immunization.

Add the following at the end of “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 82 of your United HealthCare Certificate as amended in your September 2005 Amendments.

Prostheses and orthotic devices

U. Effective January 1, 2007. Prostheses and Orthotic Devices – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual’s functional needs. Replacements, when functionally necessary, are also covered. There is no copayment for the prosthesis and/or orthotic device when you use a participating provider. Mastectomy bras obtained from participating providers are covered in accordance with this benefit.

Add the following after the third paragraph in the “Basic Medical Program” section on page 83 of your United HealthCare Certificate.

Basic Medical Provider Discount Program

You may have access through The Empire Plan Basic Medical Provider Discount Program (MultiPlan) to non-participating providers who have agreed to discount their charges for covered Basic Medical expenses. Your 20 percent coinsurance may be based on a discounted fee, rather than the reasonable and customary charges, if:

- The Empire Plan is your primary coverage;
- you receive covered Basic Medical services from the non-participating provider;
- the discounted fee is lower than the Basic Medical reasonable and customary allowance; and
- you have met your annual Basic Medical deductible.

You will not be billed for charges in excess of the discounted fee. The provider will submit claims for you and United HealthCare will pay the provider directly.

Substitute the following for “Assignment of benefits...” in the “Basic Medical Program” section on page 83 of your United HealthCare Certificate.

Assignment of benefits

Assignment of benefits to a non-participating provider is not permitted. (Assignments will be made to hospitals and for ambulance services as long as the ambulance service has a contract in effect with United HealthCare and to providers in The Empire Plan Basic Medical Provider Discount Program.)

Substitute the following for the first sentence of “A. Annual Deductible” under “You must meet a deductible and pay 20% coinsurance...” in the “Basic Medical Program” section on page 83 of your United HealthCare Certificate.

Annual deductible

For calendar year 2007, the Basic Medical annual deductible for medical services performed and supplies prescribed by non-participating providers is \$335 for the enrollee, \$335 for the enrolled spouse/domestic partner, and \$335 for all dependent children combined.

Coverage

Substitute the following for the last paragraph of “A. Hospitals” under “What is covered ...” in the “Basic Medical Program” section on page 84 of your United HealthCare Certificate.

United HealthCare will provide coverage for services and supplies in connection with Infertility Benefits and Cancer Resource Services whether or not benefits are available under The Empire Plan’s hospital benefits plan.

Add the following after “A. Hospitals” under “What is covered ...” in the “Basic Medical Program” section on page 84 of your United HealthCare Certificate. (Adjust the letters that follow.)

Non-network Hospital Program expenses

B. Effective January 1, 2007. Non-network Hospital, Skilled Nursing Facility and Hospice Care Facility Out-of-Pocket Expenses – If The Empire Plan provides your primary coverage and you incur out-of-pocket expenses under the Hospital Program as the result of using a non-network hospital, skilled nursing facility or hospice care facility for covered services, you may submit a claim to United HealthCare for reimbursement of any such expenses over \$500 up to the combined \$1,500 non-network hospital, skilled nursing facility or hospice care facility coinsurance maximum. This reimbursement is not subject to the Basic Medical deductible or coinsurance. **Any hospital deductibles or coinsurance amounts applied because you failed to meet the requirements of the Benefits Management Program are not reimbursable nor do they count toward the \$500 threshold for reimbursement.** You must provide United HealthCare with a copy of your Empire BlueCross BlueShield explanation of benefits to document the amount of your covered out-of-pocket expense.

Radiology, anesthesiology, pathology

C. Effective January 1, 2007. Radiology, Anesthesiology and Pathology – If you receive anesthesia, radiology or pathology services in connection with inpatient or outpatient hospital services at an Empire Plan network hospital, and The Empire Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by United HealthCare.

Substitute the following for “O. Prosthetics” under “What is covered ...” in the “Basic Medical Program” section on page 85 of your United HealthCare Certificate.

Prostheses and orthotic devices

Q. Effective January 1, 2007. Prostheses and Orthotic Devices – One prosthesis and/or orthotic device per affected body part meeting an individual’s functional needs is covered. Replacements when functionally necessary are also covered.

Substitute the following for “R. Hearing Aids” under “What is covered...” in the “Basic Medical Program” section on page 85 of your United HealthCare Certificate.

Hearing aids

T. Hearing Aids -- Effective January 1, 2007. Hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of \$1,200 per hearing aid per ear, once every four years. Children age 12 years and under are eligible to receive a benefit of up to \$1,200 per hearing aid per ear, once every two years when it is demonstrated that a covered child’s hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child’s hearing loss. *These benefits are not subject to deductible or coinsurance.*

Add the following at the end of “What is covered...” in the “Basic Medical Program” section on page 86 of your United HealthCare Certificate.

Mastectomy prostheses

AB. Effective January 1, 2007. Mastectomy Prostheses – One single or double mastectomy prosthesis per calendar year is covered in full. Any single external mastectomy prosthesis costing \$1,000 or more requires approval through the Home Care Advocacy Program (HCAP). Call HCAP toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose United HealthCare before you

purchase the prosthesis. For a prosthesis requiring approval, if a less expensive prosthesis can meet an individual's functional needs, benefits will be available for the most cost-effective choice. *This benefit is not subject to deductible or coinsurance.*

Hospital admission

Substitute the following for "Pre-Admission Certification: Hospital" in the "Benefits Management Program" section on page 86 of your United HealthCare Certificate.

Effective January 1, 2007. If you do not comply with Pre-Admission Certification requirements for hospital admission, you will be subject to paying a \$200 hospital deductible. No payment will be made for any day it is determined that your hospitalization is not medically necessary.

HCAP

Substitute the following for the second paragraph of "A. Durable Medical Equipment" under "HCAP-covered Durable Medical Equipment and Supplies" in the "Home Care Advocacy Program" section on page 87 of your United HealthCare Certificate.

Examples of durable medical equipment covered under HCAP that may be considered medically necessary when prescribed by your doctor include, but are not limited to: hospital-type beds, equipment needed to increase mobility (such as a wheelchair), respirators or other equipment for the use of oxygen, and monitoring devices. Items not covered under HCAP such as prosthetics, braces (except cervical collars) and splints, will be considered under the Participating Provider Program or the Basic Medical Program.

Infertility benefits

Substitute the following for the second paragraph of "Infertility Benefits" on page 92 of your United HealthCare Certificate.

Infertility benefits, including Qualified Procedures, are subject to the same copayments, deductibles, coinsurance maximums and percentages payable as benefits for other medical conditions under the Participating Provider and Basic Medical programs. Effective January 1, 2007, Qualified Procedures are subject to a \$50,000 lifetime maximum.

Substitute the following for "Maximum lifetime benefit" in the "Infertility Benefits" section on page 93 of your United HealthCare Certificate.

Benefits paid for Qualified Procedures under The Empire Plan are subject to a lifetime maximum of \$50,000 per covered individual. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures.

Infertility Centers of Excellence

Substitute the following for the second paragraph under "Infertility Centers of Excellence" in the "Infertility Benefits" section on page 93 of your United HealthCare Certificate.

When attending an Infertility Center of Excellence for Qualified Procedures more than 100 miles from a patient's residence, benefits are also available for travel, lodging and meal expenses. Reasonable expenses for the patient and one family member companion traveling on the same day to and/or from the center are payable under this infertility benefit. Travel by private automobile will be reimbursed at the Internal Revenue Service per-mile rate in force at the time. Available coach airfare is covered only when the authorized Infertility Center of Excellence is more than 200 miles from a patient's residence. These benefits are available only if the expenses have been pre-authorized by United HealthCare and are applied toward the \$50,000 maximum lifetime benefit.

Add the following after “Infertility Benefits” on page 94 of your United HealthCare Certificate.

Cancer Program

Centers of Excellence for Cancer Program

The Centers of Excellence for Cancer Program provides paid-in-full coverage for cancer-related expenses received through a nationwide network known as Cancer Resource Services (CRS). If you choose to participate in the Centers of Excellence for Cancer Program, you receive enhanced benefits as detailed below. The enhanced benefits include travel reimbursement and a paid-in-full benefit for services covered under the Program and performed at one of the CRS Centers of Excellence. You will also have access to health care nurse consultants who will answer your cancer-related questions and help you understand your cancer diagnosis. Participation in the Centers of Excellence for Cancer Program is voluntary, but the enhanced benefits under the Program are available only when you have enrolled with the Cancer Resource Services and notified your case manager before obtaining services.

Centers of Excellence. Facilities covered under the Centers of Excellence for Cancer Program include some of the best cancer centers in the United States. For a current list of Centers of Excellence for Cancer, call The Empire Plan toll-free number, 1-877-7-NYSHIP (1-877-769-7447), and select United HealthCare, then Cancer Resource Services.

What is covered? You receive paid-in-full benefits for the following services:

- Inpatient and outpatient hospital and physician care related to the cancer treatment and provided by one of the CRS-contracted Centers of Excellence.
- Cancer clinical trials and related treatment and services. Such treatment and services must be recommended and provided by a physician in a cancer center. The cancer center must be a participating facility in the Cancer Resource Services network at the time the treatment or service is given.

When the above services have been authorized by CRS and provided at a CRS Center of Excellence facility, you will not have to make any copayments for services rendered at the Center. Also, once enrolled in the Program, when the facility is more than 100 miles from the patient’s home, a travel, lodging and meals benefit is available to the patient and one travel companion. Available coach airfare is covered when the CRS Center of Excellence facility is more than 200 miles from the patient’s home.

Enrollment. To receive the paid-in-full benefit and the travel benefit, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447). Select United HealthCare and then Cancer Resource Services to enroll in the Program.

Other benefits still available. The Centers of Excellence for Cancer Program is voluntary. If you choose not to enroll in the Program, you are still eligible for Empire Plan benefits for your covered cancer treatment. Covered medical/surgical services may be available under the Participating Provider Program or the Basic Medical Program through United HealthCare. Covered hospital services may be available through Empire BlueCross BlueShield. You also will have to comply with the requirements of The Empire Plan Benefits Management Program and will have to pay any applicable deductible, coinsurance and copayments.

Substitute the following for “A.” of “How” and “A.” of “When” in the “How, When and Where to Submit Claims” section on page 99 of your United HealthCare Certificate.

Claims: How

A. If you go to a participating provider or MPN Network provider, or a Basic Medical Provider Discount Program provider, all you have to do is ensure that the provider has accurate and up-to-date personal information—name,

address, identification number, signature—needed to complete the claim form. Your participating provider, MPN Network provider, HCAP-approved provider or Discount Program provider fills out the form and sends it directly to United HealthCare. The claim forms are in each provider's office.

Claims: When

A. If you use a participating provider, MPN Network provider, HCAP Network provider or a Basic Medical Provider Discount Program provider, your provider will submit a claim to United HealthCare.

GHI CERTIFICATE OF INSURANCE

Empire Plan Mental Health and Substance Abuse Program

Substitute the following for the second paragraph of "Emergency services" in the "How to Receive Benefits for Mental Health and Substance Abuse Care" section on page 111 of your GHI Certificate as amended in your January 2004 Empire Plan Report.

Emergency services

Effective January 1, 2007. You must pay the first \$50 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this \$50 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for "d." under "NETWORK COVERAGE" in the "Schedule of Benefits for Covered Services" on page 114 of your GHI Certificate as amended in your January 2004 Empire Plan Report.

Effective January 1, 2007. d. You pay the first \$50 charged for emergency care in a hospital emergency room. You will not have to pay this \$50 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

Substitute the following for "b." under "NETWORK COVERAGE" in the "Schedule of Benefits for Covered Services" on page 116 of your GHI Certificate.

Outpatient rehabilitation program

b. **Effective January 1, 2007.** You pay the first \$15 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse

Substitute the following for "f" under "NON-NETWORK COVERAGE" in the "Schedule of Benefits for Covered Services" on page 119 of your GHI Certificate.

Lifetime maximum

Effective January 1, 2007. The lifetime maximum benefit for substance abuse care, including alcoholism, under the non-network coverage is \$250,000 for you, the enrollee, and \$250,000 for each of your covered dependents.

**EMPIRE BLUECROSS BLUESHIELD
CERTIFICATE OF INSURANCE**

Empire Plan Prescription Drug Program

Substitute the following for the CIGNA Certificate of Insurance on pages 131-144 of your Empire Plan Certificate.

**Certificate
of Insurance**

**Section V
EMPIRE HEALTHCHOICE ASSURANCE, INC.**

doing business as

**EMPIRE BLUECROSS BLUESHIELD
CERTIFICATE OF INSURANCE**

Empire Plan Prescription Drug Program

Empire HealthChoice Assurance, Inc. (the “Insurer”) insures and jointly administers The Empire Plan Prescription Drug Program (the “Program”). CaremarkPCS Health, LLC and its affiliates (“Caremark”) is the pharmacy benefit administrator and the Mail Service Pharmacy.

Meaning of Terms Used

The following terms used in this Certificate with either upper or lower case initial letters shall have the following meanings.

- 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. **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.
- D. **Pharmacy** means an 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, and regularly dispenses medications that require a Prescription from a Doctor. Drugs described in the section “*What Is Covered*” must be regularly dispensed from the Pharmacy by a Pharmacist.
- E. **Network Pharmacy** means a Pharmacy, other than the Mail Service Pharmacy, that has entered into a contract with Caremark as an independent contractor to dispense drugs per the terms of the contract.
- F. **Non-Network Pharmacy** means any Pharmacy, other than the Mail Service Pharmacy, that has not entered into a contract with Caremark to dispense drugs per the terms of the contract. The Enrollee must file a claim form with the Insurer in order to receive reimbursement for covered drugs received from a Non-Network Pharmacy.
- G. **Mail Service Pharmacy** means the specific Mail Service Pharmacy(ies) that has entered into an agreement with Caremark to provide prescription drugs to enrollees through the mail. The Mail Service Pharmacy shall dispense drugs per the terms of this Certificate and in accordance with the laws, rules and regulations that govern pharmacy practice.

- H. **Doctor** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), who is legally licensed, without limitations, 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.
- I. **Prescription** means 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 be an authorized refill of that order.
- J. **Brand-Name Drug** means a prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition.
- Preferred Brand-Name Drug** means a Brand-Name Drug that has been placed on The Empire Plan Preferred Drug List by the Insurer.
- Non-Preferred Brand-Name Drug** means a Brand-Name Drug that has not been placed on The Empire Plan Preferred Drug List by the Insurer.
- K. **Generic Drug** means a drug sold under its chemical name or sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug.
- 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 Drug** means any drug that, as determined by the Insurer, is:
1. Provided for the diagnosis or treatment of a medical condition;
 2. Appropriate for the symptoms, diagnosis or treatment of a medical condition,
 3. Within the standards of generally accepted health care practice; and
 4. Not used for cosmetic purposes.

If your claim is denied 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 the Pharmacy 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 that is required by law. It provides medical or dental care payments, that 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 that 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

Your prescription drug benefit is based on whether a drug is Generic, Preferred Brand-Name or Non-Preferred Brand-Name. Copayments are based on the drug, the days' supply and whether the Prescription is filled at a Network Pharmacy or the Mail Service Pharmacy.

When you fill your Prescription for up to a **30-day supply at a Network Pharmacy or through the Mail Service Pharmacy**, your copayment is:

- **\$5** for a **Generic Drug**
- **\$15** for a **Preferred Brand-Name Drug**
- **\$30** for a **Non-Preferred Brand-Name Drug**

When you fill your Prescription for a **31- to 90-day supply at a Network Pharmacy**, your copayment is:

- **\$10** for a **Generic Drug**
- **\$30** for a **Preferred Brand-Name Drug**
- **\$60** for a **Non-Preferred Brand-Name Drug**

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

- **\$5** for a **Generic Drug**
- **\$20** for a **Preferred Brand-Name Drug**
- **\$55** for a **Non-Preferred Brand-Name Drug**

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.

If the full cost of the drug is less than your copayment, your cost is the lesser amount.

Mandatory Generic Substitution

When your Prescription is written Dispense As Written (DAW) for a Brand-Name Drug that has a generic equivalent, you pay the Non-Preferred Brand-Name copayment plus the difference in cost between the Brand-Name and the Generic Drug, not to exceed the full cost of the drug. Otherwise, the generic equivalent is substituted for the Brand-Name Drug and you pay the Generic Drug copayment.

The following Brand-Name Drugs are excluded from mandatory generic substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid and Tegretol. For these drugs, you pay only the applicable copayment, which in most cases will be the Non-Preferred Brand-Name copayment.

If your Doctor believes it is medically necessary for you or your family member to have a Brand-Name Drug (that has a generic equivalent), you may appeal the mandatory generic substitution requirement. For an appeal form that you and your Doctor must complete, call toll free 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program. Or, you can write for a generic appeal form to:

The Empire Plan Prescription Drug Program
P.O. Box 11826
Albany, NY 12211

Act promptly. The Insurer will go back only 30 days from the date of receipt of a completed appeals form to adjust claims.

If your appeal is granted and you fill your prescription for the Brand-Name Drug at an Empire Plan Network Pharmacy or through the Mail Service Pharmacy, you pay the Non-Preferred copayment. If your appeal is denied, you can make a second appeal to the 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 Network Pharmacy, the Mail Service Pharmacy or a Non-Network Pharmacy.

Prior authorization required for certain drugs

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for certain medications. If your Doctor prescribes one of these drugs, the Insurer will request from your Doctor the clinical information required to authorize the medication. Your Pharmacy or Doctor may contact the Insurer to begin the authorization process. The Insurer and/or pharmacy will notify you of the results of the review. The prior authorization requirements apply whether you use your Empire Plan Benefit Card or will be filing a claim for direct reimbursement. The following is a list of drugs that require prior authorization:

- Amevive
- Aranesp
- Arixtra
- Avonex
- Betaseron
- Botox
- Copaxone
- Enbrel
- Epogen/Procrit
- Flolan
- Forteo
- Fragmin
- Growth Hormones
- Humira
- Immune Globulins
- Increlex
- Infergen
- Innohep
- Intron-A
- Iplex
- Kineret
- Lamisil
- Lovenox
- Myobloc
- Orenzia
- Pegasys
- Peg-Intron
- Provigil
- Raptiva
- Rebif
- Remicade
- Remodulin
- Revatio
- Sporanox
- Synagis
- Tracleer
- Tysabri
- Ventavis
- Xolair

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. This list of drugs is subject to change. For the most current list of drugs requiring prior authorization, call The Empire Plan Prescription Drug Program at the number below or go to the New York State Department of Civil Service web site at www.cs.state.ny.us. For more information about drugs requiring prior authorization and how to obtain it, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

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 allows you or your Doctor to ask for further review if authorization is not granted. You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program for information on how to initiate an appeal.

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 and dispensed by a Pharmacy or the Mail Service Pharmacy:

- A. Federal Legend Drugs. Drugs or medicines whose labels must bear the legend: *RX Only*
- B. State Restricted Drugs. Drugs or medicines that can be dispensed in accordance with New York State Law (or by the laws of the state or jurisdiction in which the Prescription is filled) by Prescription only
- C. Compound Drug. A compound drug is defined as two or more ingredients (solid, semi-solid or liquid), at least one of which is a covered drug with a valid National Drug Code (NDC) requiring a prescription for dispensing, combined together in a method specified in a prescription issued by a Doctor. The end result of this combination must be a prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer.
At least one ingredient must be a prescription drug product with a valid NDC.

The prescription must identify the multiple ingredients in the compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use.

The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA-approved package insert prior to dispensing will not be considered a compound prescription by this Plan.

- D. Injectable insulin
- E. Oral, injectable or surgically implanted contraceptives that are Federal Legend Drugs, diaphragms and contraceptive devices
- F. Vitamins that are Federal Legend Drugs
- G. Prescription drugs dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility; rest home; sanitarium; extended care facility; convalescent hospital; or similar facility. Such on-premises pharmacies are considered Non-Network Pharmacies and require submission of a claim form for reimbursement.

Please refer to the section “*Exclusions and Limitations*” below for conditions under which benefits for the above 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

This limit applies only if the hospital in which you are a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals; and dispenses such drugs administered to you by the hospital.

- F. Any drug refill that is more than the number approved by the Doctor
- G. Contraceptive jellies, ointments and foams or devices not requiring a Doctor’s order, 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 that 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 Section 3221(1)12 of New York State Insurance Law as may be amended from time to time: 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 that the U.S. 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. 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 that 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*”.
- 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 anorexiant, except for morbid obesity
 2. Amphetamines that are prescribed for weight loss, except for morbid obesity
 3. Products used to promote hair growth
 4. Products (ex. Retinoic Acid) used for prevention of skin wrinkling
- R. Any non-medically necessary drugs

IMPORTANT: See your *NYSHIP General Information Book and Empire Plan Certificate* 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 up to one year in one of three ways: at a Network Pharmacy, at a Non-Network Pharmacy or through the Mail Service Pharmacy.

Network Pharmacies

You can use your Empire Plan Benefit Card for covered prescription drugs at Empire Plan Network Pharmacies. Be sure your Pharmacist knows that you and your family have Empire Plan Prescription Drug Program coverage.

To find a Network Pharmacy, check with your Pharmacist or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

Many retail pharmacies in New York State participate in this Program. Many out-of-State pharmacies participate, as well. All Empire Plan Network 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-Network Pharmacies

You can use a Non-Network Pharmacy or pay the full amount for your Prescription at a Network Pharmacy (instead of using your Empire Plan 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 Empire Plan 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 Network Pharmacy for that Prescription as calculated using the Program’s standard reimbursement rate for Network 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 Network Pharmacy for filling the Prescription with that drug's generic equivalent as calculated using the Program's standard reimbursement rates for Network Pharmacies less the applicable copayment, which in most cases will be the Non-Preferred copayment.

Out-of-pocket expenses: When you use a Non-Network Pharmacy or pay the full amount for your Prescription at a Network Pharmacy, you are responsible for the difference between the amount charged and the amount you are reimbursed under this Program.

For claim forms, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

Mail the completed form with your bills or receipts to:

The Empire Plan Prescription Drug Program
P.O. Box 52071
Phoenix, AZ 85072-2071

Using the Preferred Drug List

One way you can help control the rapidly increasing cost of prescription drugs is by encouraging your Doctors and Pharmacist to use the preferred list of drugs. (The Empire Plan Preferred Drug List is available at www.cs.state.ny.us.)

This list provides the most commonly prescribed Generic and Brand-Name Drugs included on The Empire Plan Preferred Drug List. These medications are safe and effective alternatives to higher cost drugs. Using Prescription drugs that appear on this list will save you money. Using generics will save you even more.

For example one antibiotic can cost \$70. Another, equally safe and effective antibiotic used for many of the same conditions, can cost just \$10.

The Insurer will provide this preferred list of drugs to you and to Empire Plan participating Doctors. Doctors are encouraged - but not required - to use this 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.

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 from the Mail Service Pharmacy, 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. To request mail service envelopes, refills or to speak to a Pharmacist about your mail service Prescription, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program, 24 hours a day, seven days a week.

The Mail Service Pharmacy address is:

Caremark Mail Service
P.O. Box 3223
Wilkes-Barre, PA 18773-3223

Call The Empire Plan Prescription Drug Program

For questions about your Empire Plan Prescription Drug Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program. The Teletypewriter (TTY) number for callers with a hearing or speech disability is 1-800-863-5488.

Call 24 hours a day, 7 days a week if you need to:

- Verify your eligibility
- Find out if your claims have been paid
- Locate an Empire Plan Network Pharmacy
- Order refills from the Mail Service Pharmacy or check order status
- Talk to a customer service representative
- Request prior authorization or a generic appeal
- Talk to a Pharmacist

Coordination of Benefits

A. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan Prescription Drug Program are coordinated with the benefits provided for you under another group 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 total allowable charge for a service covered under both group plans. If a covered drug is submitted under the Program, the Program will reimburse the enrollee the submitted balance or the amount that would have been paid as a network benefit under The Empire Plan, whichever is lower. In addition, if you or any of your dependents is covered under two separate Empire Plan policies, you may submit Empire Plan copayments for reimbursement under your secondary Empire Plan coverage using a paper claim form.

B. Definitions

1. **Plan** means a plan that provides benefits or services for or by reason of medical or dental care and that is:
 - a. A group insurance plan; or
 - b. 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
 - c. A self-insured or non-insured plan; or
 - d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
 - e. A group service plan; or
 - f. A group prepayment plan; or
 - g. Any other plan that covers people as a group; or
 - h. 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.
2. **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 that 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 that do not.

C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all

payments or benefits payable under The Empire Plan and under another plan is not more than the total allowable charge for the service you receive.

- D. 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 E. and under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.
- E. 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 that applies:
1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent;
 2. 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 3. below)
 - a. 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;
 - b. If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time;
 - c. If the other plan does not have the rule described in subparagraphs a. and b. 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; and
 - d. The word birthday refers only to month and day in a calendar year, not the year in which the person was born.
 3. 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:
 - a. First, the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent with custody of the child;
 - c. Finally, the plan of the parent not having custody of the child; and
 - d. 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.
 4. The benefits of a plan that 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 that 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 4. is ignored.
 5. If none of the rules in 1. through 4. above determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.

- F. 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.
- G. Any information about covered expenses and benefits that 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.
- H. 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.
- I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts that are considered proper under this provision.

Medicare Prescription Drug Coverage

If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, read the following information about how to use your Empire Plan benefits for secondary coverage.

A Medicare-primary Empire Plan enrollee or dependent enrolled in a Medicare Part D drug plan must use his or her Medicare Part D prescription drug program first. Any amounts not covered by your Medicare Part D plan, such as deductibles, copayments and charges for non-covered drugs, can be submitted to The Empire Plan for consideration using The Empire Plan Prescription Drug Program claim form specifically labeled Medicare Part D Secondary Claim Form. This claim form is available on the New York State Department of Civil Service web site, www.cs.state.ny.us. The form is also available by calling The Empire Plan Prescription Drug Program at 1-877-7-NYSHIP (1-877-769-7447). When you call, be sure to ask for the Medicare Part D claim form.

At retail pharmacies: Any claim submitted to The Empire Plan Prescription Drug Program by a retail pharmacy will be rejected and the Pharmacist will be advised that you have alternate insurance, which is your Medicare Part D drug plan. You are responsible for providing the Pharmacist with the necessary Medicare Part D plan information to submit the claim. Then, you must follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

At the Caremark Mail Service Pharmacy: Any prescription sent to the Caremark Mail Service Pharmacy for a Medicare-primary Empire Plan enrollee or dependent who is also enrolled in a Medicare Part D drug plan will be rejected and returned. You must use your Medicare Part D drug plan first and then follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

IMPORTANT: If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, you must submit your out-of-pocket expenses to The Empire Plan Prescription Drug Program using The Empire Plan Prescription Drug Program Medicare Part D Secondary Claim Form only. Your claim will be processed in accordance with the coordination of benefits provisions of The Empire Plan Prescription Drug Program. If you use the standard Empire Plan Prescription Drug Program claim form, your claim will be rejected and you will have to resubmit it using the Medicare Part D Secondary Claim Form.

Miscellaneous Provisions

Termination of coverage

A. 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 The Empire Plan temporarily after eligibility ends. Refer to the COBRA section of your *NYSHIP General Information Book*.

B. If this Program ends, your Program coverage will end.

C. 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 The Empire Plan temporarily after eligibility ends. Refer to the COBRA section of your *NYSHIP General Information Book*.

D. If a payment that is required from you toward the cost of The Empire Plan coverage is not made, the coverage will end on the last day of the period for which a payment was made.

E. If coverage ends, any claim incurred before your coverage ends for any reason will not be affected; also, see “*Benefits after termination of coverage*” below.

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

The Insurer 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 Empire Plan Benefit Card after eligibility ends constitutes fraud.

Audits/prescription benefit records

From time to time, the Insurer may ask you to verify receipt of particular drugs from Network Pharmacies or from the Mail Service Pharmacy. 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:

The Empire Plan Prescription Drug Program
Complaints and Appeals Unit
P.O. Box 11826
Mail Drop 3H
Albany, NY 12211

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, One Commerce Plaza, Albany, NY 12257. Phone: 1-800-342-3736, Monday - Friday, 9 a.m. - 5 p.m.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Insurer 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 the Insurer must have upheld the denial or you and the Insurer 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 the Insurer must have upheld the denial or you and the Insurer must agree in writing to waive any internal appeal.

In addition, your attending Doctor must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one that, according to the current diagnosis of your attending Doctor, 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 Doctor 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 Doctor 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 Doctor 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 Doctor 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 the Insurer 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. The Insurer will provide an external appeal application with the final adverse determination issued through the Insurer'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 the Insurer based its denial, the External Appeal Agent will share this information with the Insurer in order for it to exercise its right to reconsider its decision. If the Insurer chooses to exercise this right, the Insurer will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Insurer 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 Doctor or the Insurer. 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 Doctor 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 the Insurer 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 the Insurer's decision that a service is not medically necessary or approves coverage of an experimental or investigational drug, the Insurer 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 the Insurer. The External Appeal Agent's decision is admissible in any court proceeding.

The Insurer 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. The Insurer 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 Doctor 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 the Insurer that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Insurer 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 to ensure that your medications are appropriate and your benefit dollars are being spent wisely.

The DUR process

This review process generally 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 Empire Plan Benefit Card at a Network 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, a “behind the scenes” safety review is conducted to identify any potential drug therapy related problems. 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 these reviews are confidential and that pertinent information is shared only with your Pharmacist and Doctor or as permitted or required by law.

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, The Empire Plan Prescription Drug Program has a patient education program.

For doctors

To help your Doctor keep up to date on the most current information on prescription drugs, The Empire Plan has a doctor education program.

October 1, 2006 Empire Plan Copayments for Employees of New York State Represented by C-82 (September 8, 2006 Binding Arbitration)

Services by Empire Plan Participating Providers

You pay only your copayment when you choose Empire Plan Participating Providers for covered services. Check your directory for Participating Providers in your geographic area, or ask your provider. For Empire Plan Participating Providers in other areas and to check a provider's current status, call United HealthCare at 1-877-7-NYSHIP (1-877-769-7447) toll free or use the Participating Provider Directory on the internet at www.cs.state.ny.us.

Office Visit	\$15
Office Surgery	\$15
(If there are both an Office Visit charge and an Office Surgery charge by a Participating Provider in a single visit, only one copayment will apply, in addition to any copayment due for Radiology/Laboratory Tests.)	
Radiology, Single or Series; Diagnostic Laboratory Tests	\$15
(If Outpatient Radiology and Outpatient Diagnostic Laboratory Tests are charged by a Participating Provider during a single visit, only one copayment will apply, in addition to any copayment due for Office Visit/Office Surgery.)	
Mammography, according to guidelines	\$15
Adult Immunizations	\$15
Allergen Immunotherapy	No copayment
Well-Child Office Visit, including Routine Pediatric Immunizations	No copayment
Prenatal Visits and Six-Week Check-Up after Delivery	No copayment
Chemotherapy, Radiation Therapy, Dialysis	No copayment
Authorized care at Infertility Center of Excellence	No copayment
Hospital-based Cardiac Rehabilitation Center	No copayment
Free-standing Cardiac Rehabilitation Center visit	\$15
Urgent Care Center	\$15
Contraceptive Drugs and Devices when dispensed in a doctor's office	\$15
(in addition to any copayment(s) due for Office Visit/Office Surgery and Radiology/Laboratory Tests)	
Anesthesiology, Radiology, Pathology in connection with inpatient or outpatient network hospital services	No copayment
Ambulatory Surgical Center (including Anesthesiology and same-day pre-operative testing done at the center)	\$15
Medically appropriate local commercial ambulance transportation	\$35

Chiropractic Treatment or Physical Therapy Services by Managed Physical Network (MPN) Providers

You pay only your copayment when you choose MPN network providers for covered services. To find an MPN network provider, ask the provider directly, or call United HealthCare at 1-877-7-NYSHIP (1-877-769-7447) toll free. Internet: www.cs.state.ny.us.

Office Visit	\$15
Radiology; Diagnostic Laboratory Tests	\$15
(If Radiology and Laboratory Tests are charged by an MPN network provider during a single visit, only one copayment will apply, in addition to any copayment due for Office Visit.)	

Hospital Outpatient Department Services

Emergency Care	\$50*
(The \$50 hospital outpatient copayment covers use of the facility for Emergency Room Care , including services of the attending emergency room physician <i>and</i> providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.)	

Network Hospital Outpatient Department Services

Surgery	\$35*
Diagnostic Laboratory Tests	\$35*
Diagnostic Radiology (including mammography, according to guidelines)	\$35*
Administration of Desferal for Cooley's Anemia	\$35*
Physical Therapy (following related surgery or hospitalization)	\$15
Chemotherapy, Radiation Therapy, Dialysis	No copayment
Pre-Admission Testing/Pre-Surgical Testing prior to inpatient admission ...	No copayment
* Only one copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The copayment covers the outpatient facility. Provider services may be billed separately. You will not have to pay the facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you, at that time, as an inpatient.	
Be sure to follow Benefits Management Program requirements for hospital admissions, skilled nursing facility admission and Magnetic Resonance Imaging.	

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

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

Visit to Outpatient Substance Abuse Treatment Program	\$15
Visit to Mental Health Professional	\$15
Psychiatric Second Opinion when Pre-Certified	No copayment
Mental Health Crisis Intervention (three visits)	No copayment
Inpatient	No copayment

Empire Plan Prescription Drugs

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

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

Generic Drug	\$5
Preferred Brand-Name Drug	\$15
Non-Preferred Brand-Name Drug	\$30**

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

Generic Drug	\$10
Preferred Brand-Name Drug	\$30
Non-Preferred Brand-Name Drug	\$60**

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

Generic Drug	\$5
Preferred Brand-Name Drug	\$20
Non-Preferred Brand-Name Drug	\$55**

**If you choose to purchase a brand-name drug that
has a generic equivalent, you pay the non-preferred
brand-name copayment *plus* the difference in cost
between the brand-name drug and its generic
equivalent (with some exceptions), not to exceed the
full cost of the drug.

Notes

Notes