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

NYSHIP
New York State Health Insurance Program

General Information & Book Empire Plan Certificate Amendments

For New York State Police Troopers
represented by the **Police Benevolent Association**
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

New York State Health Insurance Program General Information Book

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

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

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Add the following as the 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 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.

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

Exception for court order

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.

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.

IRS regulations

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.

EMPIRE BLUECROSS BLUESHIELD CERTIFICATE OF INSURANCE

Substitute the following for the second paragraph of "2. B." in the "Network and Non-network Benefits" section on page 52 of your Empire BlueCross BlueShield Certificate as amended in your September 2005 Amendments.

Non-network benefits

The **annual coinsurance maximum** for covered inpatient/outpatient services received at a non-network hospital and covered inpatient services received at a non-network skilled nursing facility or hospice care facility is $1,500 for the enrollee, $1,500 for the enrolled spouse/domestic partner, and $1,500 for all dependent children combined. After the maximum levels have been reached, inpatient services are paid in full, hospital emergency room visits are subject to a $60 copayment, hospital outpatient services are subject to a $35 copayment and physical therapy services are subject to an $18 copayment. Once you have paid $500 in non-network coinsurance, amounts in excess of $500 are reimbursable under the Basic Medical Program.

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 as amended in your September 2005 Amendments.

Physical therapy

Effective January 1, 2007. You pay an $18 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 "Copayment for emergency care" in the "Outpatient Hospital Care" section on pages 54-55 of your Empire BlueCross BlueShield Certificate as amended in your September 2005 Amendments.

Copayment for emergency care

Effective January 1, 2007. You must pay the first $60 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 $60 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 $60 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 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.

Transplants Program

When the above services are pre-authorized by Empire BlueCross BlueShield and provided at a Center of Excellence for Transplants facility, you will not have to make any copayments, and a travel, 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.

Other benefits

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 transplant.

UNITED HEALTHCARE CERTIFICATE OF INSURANCE

$18 copayment

Effective January 1, 2007. *Substitute "$18 copayment" for "$15 copayment" wherever the $15 appears in your United HealthCare Certificate as amended in your September 2005 Amendments.*

Coinsurance maximum

Substitute "$1,241 in calendar year 2007" in the first and second paragraphs of "T. 2. b. The covered percentage" under "Meaning of Terms Used" on pages 78-79 of your United HealthCare Certificate.

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.

Substitute the following for the first sentence of "A. Annual Deductible" 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.

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 as amended in your September 2005 Amendments.

Hearing aids

T. **Hearing Aids — Effective January 1, 2006.** Hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of $1,500 per hearing aid per ear, once every four years. Children age 12 years and under are eligible to receive a benefit of up to $1,500 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.*

Substitute the following for the second paragraph under "What is covered" in the "Centers of Excellence for Cancer Program" on page 94 of your United HealthCare Certificate as amended in your September 2005 Amendments.

Cancer Program

When the above services have been authorized by CRS and provided at a CRS Center of Excellence facility, you will not have to make any copayments for services rendered at the Center. Also, once enrolled in the Program, when the facility is more than 100 miles 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.

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 114 of your GHI Certificate as amended in your September 2005 Amendments.

Emergency services

Effective January 1, 2007. You must pay the first $60 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this $60 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 118 of your GHI Certificate as amended in your September 2005 Amendments.

Effective January 1, 2007. d. You pay the first $60 charged for emergency care in a hospital emergency room. You will not have to pay this $60 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 the first two paragraphs of Network Coverage on page 118 of your GHI Certificate as amended in your September 2005 Amendments.

Copayments

If you follow the requirements for network coverage, you are responsible for paying only the following copayments:

a. No copayments are required for inpatient care.
b. You pay the first $18 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.
c. You pay the first $18 charged for any other outpatient visit including Home-Based and Telephone Counseling in place of an office visit, except no copayment is required for:
   - Crisis Intervention, up to three visits per crisis
   - Electro-convulsive Therapy - facility and therapist charges, if certified by ValueOptions

- Psychiatric Second Opinion, if requested and certified by ValueOptions
- Ambulance Service
- Mental Health Psychiatric Evaluations, if requested and certified by ValueOptions
- Prescription drugs, if billed by an approved facility
- Home-based counseling when provided in place of inpatient care.

The network provider from whom you receive covered services is responsible for collecting the copayment from you.

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
- Orencia
- 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 anorexiants, 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 which 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.

2007 Empire Plan Copayments for Employees of New York State Represented by PBA

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 $18

Office Surgery $18

(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 $18

(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 $18

Adult Immunizations $18

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 $18

Urgent Care Center $18

Contraceptive Drugs and Devices when
dispensed in a doctor's office $18
(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 $18

Radiology; Diagnostic Laboratory Tests $18

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

Hospital Outpatient Department Services

Emergency Care $60*

(The $60 hospital outpatient copayment covers use of the facility for **E**mergency Room Care, including services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.)

Network Hospital Outpatient Department Services

Surgery $35*

Diagnostic Laboratory Tests $35*

Diagnostic Radiology (including
mammography, according
to guidelines).....$35*

Administration of Desferal for
Cooley's Anemia $35*

Physical Therapy (following related surgery
or hospitalization) $18

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 $18

Visit to Mental Health Professional $18

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