General Information & Book Empire Plan Certificate Amendments

For Employees of the State of New York represented by **Civil Service Employees Association** and for their enrolled Dependents *and for COBRA enrollees with their benefits*

January 2009

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

Keep these amendments with your August 1, 2001 *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.

New York State Health Insurance Program General Information Book

Health Care Spending Account 240
Medicare Reimbursement 240

Empire Plan Certificate Amendments

Empire BlueCross BlueShield

Copayment.....241
Annual coinsurance maximum.....241

UnitedHealthcare

Copayment.....241
Plan Overview 241
Meaning of Key Terms 241
Chronic care 243
Basic Medical Program 243
Annual deductible 244
Non-network Hospital Program expenses 244
Exclusions 245
Coordination of Benefits 245
Medicare 245
Medicare Coverage 245

Empire Plan Mental Health and Substance Abuse Program

Copayment.....246
Overview 246
Meaning of Terms Used 246
Coinsurance maximum 246
Medicare Coverage 247
How 247
Where 247
Appeals 247

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 August 1, 2001 *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)

Substitute the following for the second and third sentences under "Other money-saving programs" in the "Costs, Pre-Tax Program and What Your Paycheck Stub Shows section on page 14 of your NYSHIP General Information Book.

Health Care Spending Account

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

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

Medicare Reimbursement

Medicare premium reimbursement

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

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is a Federal law that requires some people to pay a higher premium for their Medicare Part B coverage based on their income. If you are required to pay an income-related monthly adjustment amount in addition to the standard Medicare Part B premium, you are eligible to be reimbursed for this additional premium by NYSHIP.

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

To claim the additional IRMAA reimbursement, eligible enrollees are required to apply for and document the amount paid in excess of the standard Medicare Part B premium.

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

EMPIRE BLUECROSS BLUESHIELD CERTIFICATE OF INSURANCE

Copayment

Effective July 1, 2009. *Substitute "$15 copayment" for "$12 copayment" wherever the $12 appears in your Empire BlueCross BlueShield Certificate.*

Substitute the following for the second paragraph of item 2. B. "The ***annual coinsurance maximum****" in the "Network and non-network benefits" on page 51 of your Empire BlueCross BlueShield Certificate as amended in your January 2008 Empire Plan Report.*

Annual coinsurance maximum

Effective January 1, 2009. The **annual coinsurance maximum** for covered inpatient/outpatient services received at a non-network hospital and covered inpatient services received at a non-network skilled nursing facility or hospice care facility is $1,500 for the enrollee, $1,500 for the enrolled spouse/domestic partner, and $1,500 for all dependent children combined. After the maximum levels have been reached, inpatient services are paid in full, hospital emergency room visits are subject to a $50 copayment, hospital outpatient services are subject to a $30 copayment and physical therapy services are subject to a $12 copayment. Once you have paid $500 in non-network coinsurance, up to an additional $500 of covered services is reimbursable under the Basic Medical Program (see page 244 of these Empire Plan Amendments).

UNITEDHEALTHCARE CERTIFICATE OF INSURANCE

Copayment

Effective July 1, 2009. *Substitute "$15 copayment" for "$12 copayment" wherever the $12 appears in the UnitedHealthcare Certificate.*

Substitute the following for the second paragraph under the heading "Basic Medical Program (A Non-Participating Provider)" under "Plan Overview" on page 72 of your UnitedHealthcare Certificate.

Plan overview

You submit claims to UnitedHealthcare. For covered services and supplies, The Empire Plan reimburses you 80 percent of the reasonable and customary charges for covered services and supplies or the scheduled Pharmaceutical Amount for Pharmaceutical Products or the actual billed charges, whichever is less.

Substitute the following for the first two lines of item N. "Medically Necessary or Medical Necessity" in the "Meaning of Terms Used" section on page 75 of your UnitedHealthcare Certificate.

Meaning of Terms Used

N. **Medically Necessary or Medical Necessity** means the health care services, supplies **and** Pharmaceutical Products which are determined by UnitedHealthcare to be medically appropriate and:

Substitute the following for item O. "Covered Medical Expenses" in the "Meaning of Terms Used" section on pages 75 and 76 of your UnitedHealthcare Certificate.

O. **Covered Medical Expenses** under the Basic Medical portion of this Plan means the reasonable and customary charges for covered medical services performed or supplies prescribed by a doctor or the Scheduled Pharmaceutical Amount for Pharmaceutical Products provided by a doctor, except as otherwise provided below, due to your sickness, injury or pregnancy. A covered medical expense is incurred on the date the service, supply, or Pharmaceutical Product is received by you. In order for a charge to be a covered medical expense, the service, supply or Pharmaceutical Product must be provided by a provider as defined in paragraph C above. Charges for a service, supply or Pharmaceutical Product provided by a person or facility **not** listed in the definition of provider are **not** covered medical expenses.

The fact that a doctor recommends that a service, supply or Pharmaceutical Product be provided by person who is not a provider does not make the charge for that service a covered medical expense, even if the care provided is medically necessary. These services, supplies, and Pharmaceutical Products must be medically necessary as defined in this section. No more than the reasonable and customary charge for medical services and supplies and for Scheduled Pharmaceutical Amount for Pharmaceutical Products will be covered by the Plan. *A more detailed description of covered expenses and exclusions follows.*

Substitute the following for item 3. in "P. Reasonable and Customary Charge" under "Meaning of Terms Used" on page 76 of your UnitedHealthcare Certificate.

3. the usual charge of other doctors or other providers or in the same or similar geographic area for the same or similar service or supply.

Substitute the following for item S. "Coinsurance" in the "Meaning of Terms Used" section on page 76 of your UnitedHealthcare Certificate.

S. **Coinsurance** means the difference between the reasonable and customary charge or Scheduled Pharmaceutical Amount and the covered percentage under the **Basic Medical** Portion of the Plan. Coinsurance also means the difference between the network allowance and the covered percentage under the **Managed Physical Medicine Program** and the **Home Care Advocacy Program**. You pay the coinsurance.

Substitute the following for item T.2. "Covered Percentage" under "Meaning of Terms Used" on page 76 of your UnitedHealthcare Certificate.

2. Under the Basic Medical portion of this Plan, the covered percentage for covered medical expenses is **80 percent** of the reasonable and customary charge or the Scheduled Pharmaceutical Amount except:

   a. as provided on page 83 under *"Prospective Procedure Review: MRI"*; on page 84 under *"Home Care Advocacy Program"*; on page 89 under *"Guaranteed access"* for the Managed Physical Medicine Program and on page 89 under *"Infertility Benefits"*; and

   b. **Effective January 1, 2009. The covered percentage** becomes **100 percent** of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once the coinsurance maximum is met. In calendar year 2009, the coinsurance maximum is $500 for the enrollee, $500 for the enrolled spouse/domestic partner and $500 for all dependent children combined.

      Effective January 1, 2009. The 20 percent coinsurance you pay for yourself, your enrolled spouse/domestic partner and for all dependent children combined for covered services by non-participating providers counts toward each respective **coinsurance maximum**. Copayments for services by participating providers also count. (The copayments do not stop when you reach the coinsurance maximum.)

      The annual deductible does not count toward the coinsurance maximum. Any expenses above the reasonable and customary charge or the Scheduled Pharmaceutical Amount do not count. Expenses under the Managed Physical Medicine Program, Mental Health and Substance Abuse Program and Empire BlueCross and BlueShield Hospital Program do not count, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program.

      Once the coinsurance maximum is met, covered medical expenses will be reimbursed at 100 percent of the reasonable and customary or Scheduled Pharmaceutical Amount, or 100 percent of the billed

amount, whichever is less. You will still be responsible for any charges above the reasonable and customary or Scheduled Pharmaceutical Amount and any penalties under the benefits management programs.

Substitute the following for the fifth paragraph of "T. 2. b." under "Meaning of Terms Used" section on page 75 of your UnitedHealthcare Certificate.

Effective January 1, 2009. Each $500 coinsurance maximum will be reduced to $300 for employees in (or equated to) salary grade 6 or below.

Add the following at the end of "Meaning of Terms Used" on page 77 of your UnitedHealthcare Certificate.

AD. **Scheduled Pharmaceutical Amount** means:
For covered Pharmaceutical Products, the lower of:

a. the actual charge for such covered Pharmaceutical Product or
b. the price of such covered Pharmaceutical Product as set forth in the RED BOOK published by Thomson Reuters. This Pharmaceutical Product pricing information is updated annually on October 1st, UnitedHealthcare will provide specific pricing information to you upon request.

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

AE. **Pharmaceutical Products** means FDA approved prescription Pharmaceutical Products administered by a doctor or other provider within the scope of the provider's license. Pharmaceutical Products does not include pharmaceuticals that are dispensed to you by a licensed pharmacy, which are subject to the provisions of your prescription drug program.

Substitute the following for item R. under "What is covered under the Participating Provider Program" in the Participating Provider Program section on page 78 of your UnitedHealthcare Certificate.

Chronic care

R. **Chronic Care** – You are covered for chronic care services for chemotherapy, radiation therapy and dialysis. There is no copayment for these chronic care services or for related services rendered during the course of chemotherapy, radiation therapy or dialysis.

Substitute the following for the first paragraph of "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" under the "Basic Medical Program" on pages 80 and 81 of your UnitedHealthcare Certificate.

Basic Medical Program

You are responsible for the charges billed by a non-participating provider, and must submit a claim for benefits due. These benefits are calculated based on the following:

- First, you are liable for the deductible. It is your responsibility.
- After the deductible, covered medical expenses are considered for payment. UnitedHealthcare will reimburse you for 80 percent of the reasonable and customary charges for covered services and supplies or the Scheduled Pharmaceutical Amount, for Pharmaceutical Products, or actual billed charges whichever is less. You pay the balance of 20 percent (coinsurance) and any charges above the reasonable and customary or Scheduled Pharmaceutical Amount. The covered percentage becomes 100 percent of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once each coinsurance amount exceeds the coinsurance maximum in a calendar year.

Add the following as the second paragraph of "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" in the "Basic Medical Program" section on page 79 of your UnitedHealthcare Certificate.

You are responsible for the payment of all deductible and coinsurance amounts payable to a non-participating provider after processing of your Basic Medical claim by UnitedHealthcare. Waiver of deductible and co-insurance amounts by a non-participating provider is not permitted under the Basic Medical Program. Prior to receiving services under the Basic Medical benefit you should discuss with your non-participating provider this requirement and your potential "out of pocket" liability. The level of benefits you are entitled to is predicated on meeting all deductible and coinsurance requirements set forth in this Certificate of Insurance. The Plan reserves the right to recover from enrollees benefits paid inconsistent with the provisions of this section of the Certificate of Insurance.

Substitute the following for the first sentence of "A. Annual Deductible" in the "Basic Medical Program" section on page 79 of your UnitedHealthcare Certificate.

Annual deductible

Effective January 1, 2009. For calendar year 2009, the Basic Medical annual deductible for medical services performed and supplies prescribed by non-participating providers is $225 for the enrollee, $225 for the enrolled spouse/domestic partner, and $225 for all dependent children combined.

Substitute the following for item "B. Coverage" and "C. Covered Basic Medical Expenses" in "You must meet a deductible and pay 20% coinsurance when you choose non-participating providers" under the "Basic Medical Program" on page 81 of your UnitedHealthcare Certificate.

B. **Coverage**
UnitedHealthcare will pay **Basic Medical benefits** to the extent covered medical expenses in a calendar year **exceed the deductible and coinsurance, up to the reasonable and customary or the Scheduled Pharmaceutical Amount.**

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

Substitute the following for item B. "Non-network Hospital Program expenses" under "What is covered…" in the "Network and non-network benefits" section under the "Basic Medical Program" on page 80 of your UnitedHealthcare Certificate as amended in your September 2005 Empire Plan Report.

Non-network Hospital Program expenses

B. **Effective January 1, 2009. Non-network Hospital, Skilled Nursing Facility and Hospice Care Facility Out-of-Pocket Expenses** – If The Empire Plan provides your primary coverage and you incur $500 in out-of-pocket expenses under the Hospital Program as the result of using a non-network hospital, skilled nursing facility or hospice care facility for covered services, you may submit a claim to UnitedHealthcare for reimbursement of up to an additional $500 of covered charges for non-network hospital, skilled nursing facility or hospice facility care. This reimbursement is not subject to the Basic Medical deductible or coinsurance. **Any hospital deductibles or coinsurance amounts**

applied because you failed to meet the requirements of the Benefits Management Program are not reimbursable nor do they count toward the threshold for reimbursement. You must provide UnitedHealthcare with a copy of your Empire Blue Cross Blue Shield explanation of benefits to document the amount of your covered out-of-pocket expense.

Exclusions

In all instances where the terms "services and/or supplies", "services or supplies" or "services" are used, replace them, respectively, with "services, supplies and/or Pharmaceutical Products", "services, supplies or Pharmaceutical Products", and "services or Pharmaceutical Products" in the "Exclusions" section of "UnitedHealthcare General Provisions" on pages 91 and 92 of your UnitedHealthcare Certificate.

Substitute the following for items 1. and 3. in the "Coordination of Benefits" section of "UnitedHealthcare General Provisions" on page 93 of your UnitedHealthcare Certificate.

Coordination of Benefits

1. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of Coordination of Benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the reasonable and customary charge for a service or the Scheduled Pharmaceutical Amount for Pharmaceutical Products covered under both group plans.

3. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the reasonable and customary charge for the service or the Scheduled Pharmaceutical Amount or Pharmaceutical Product you receive.

Substitute the following for the second paragraph of item A. in the "Impact of Medicare on this Plan" section of "UnitedHealthcare General Provisions" on page 95 of your UnitedHealthcare Certificate.

Medicare

When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations rather than the Participating Provider Scheduled Allowances, the Reasonable and Customary Charge or the Scheduled Pharmaceutical Amount as defined in the Meanings of Terms used.

Add the following as item F. under "Coverage" in the "Impact of Medicare on this Plan" section on page 94 of your UnitedHealthcare Certificate.

Medicare Coverage

F. ***If you or your dependents are eligible and enrolled for coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.***

EMPIRE PLAN MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

Effective January 1, 2009. *Substitute "UnitedHealthcare Insurance Company of New York" for "Group Health Incorporated" and "UHIC-NY" for "GHI" wherever these terms appear in the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.*

Substitute "OptumHealth" for "ValueOptions" wherever the term appears in the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Copayment

Effective July 1, 2009. *Substitute "$15 copayment" for "$12 copayment" wherever the $12 appears in the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.*

Substitute the following for the last paragraph of "You will receive non-network coverage for covered services when:" under "Overview" on page 206 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Overview

If you have questions about The Empire Plan Mental Health and Substance Abuse Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-334-1897.

Substitute the following for item N. "GHI" in "Meaning of Key Terms" on page 208 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Meaning of Key Terms

N. **UHIC-NY** means UnitedHealthcare Insurance Company of New York, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.

Substitute the following for item EE. "Program" in the "Meaning of Key Terms" on page 210 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

EE. **Program** means The Empire Plan Mental Health and Substance Abuse Program. This Program provides coverage under Group Policy No. 715116 issued to the State of New York, the policyholder, by UHIC-NY.

Substitute the following for item KK. "ValueOptions" in "Meaning of Key Terms" on page 211 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

KK. **OptumHealth Behavioral Solutions** (also referred to as OptumHealth) is the company selected by the State of New York to administer The Empire Plan Mental Health and Substance Abuse Program. OptumHealth provides services for UnitedHealthcare Insurance Company of New York in the administration of this Program.

Substitute the following for the first two sentences of item A. under "NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE" on page 218 of the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Coinsurance maximum

Effective January 1, 2009. For Practitioners Services: Up to 80 percent of reasonable and customary charges for covered services after you meet the annual deductible for outpatient practitioner services which is $225 per enrollee, $225 per covered spouse/domestic partner and $225 for all covered dependents combined. The covered percentage becomes 100 percent of the reasonable and customary charge for covered services once the coinsurance maximum is met. There is a separate coinsurance maximum of $500 for the enrollee, $500 for the enrolled spouse/dependent partner and $500 for all

dependent children combined. Each $500 coinsurance maximum will be reduced to $300 for employees in (or equated to) salary grade 6 or below.

Substitute the following for item B. under "NON-NETWORK COVERAGE FOR MENTAL HEALTH CARE" on page 218 of the Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

B. For Approved Facility Services: Up to 90 percent of billed charges for covered services. After an annual coinsurance maximum of $1,500 for you, the enrollee, $1,500 for your enrolled spouse/domestic partner and $1,500 for all enrolled dependent children combined is met. Each coinsurance maximum is applied as follows:

1. You pay the first $500 of coinsurance, then
2. The Program reimburses you for the next $500 of coinsurance, upon written request of the enrollee, then
3. You pay the final $500 of coinsurance.

Delete the last sentence of the first paragraph of item A. and add the following as item F. as the last item under "Coverage" in the "Impact of Medicare on this Plan" section on page 226 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Medicare Coverage

F. ***If you or your dependents are eligible and enrolled for primary coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.***

Substitute the following for the second paragraph under the heading "How" in the "How, When and Where to Submit Claims" section on page 227 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

How

If you use non-network coverage, you must submit a claim. You may obtain a claim form from:

OptumHealth Behavioral Solutions
P.O. Box 5190
Kingston, NY 12402-5190

or

You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

Substitute the following for "Where" in the "How, When and Where to Submit Claims" section on page 228 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an *"Explanation of Medicare Benefits"* form to: OptumHealth Behavioral Solutions, P.O. Box 5190, Kingston, NY 12402-5190.

Substitute the following for the first paragraph of "Appeals: 60-day deadline" in the "Appeals" section on page 229 of your Mental Health and Substance Abuse Certificate in your January 2008 Empire Plan Report.

Appeals

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 60 days after you receive a notice of denial of the certification or claim to:

OptumHealth Behavioral Solutions
Attn: BH Appeals Dept.
900 Watervliet Shaker Road, Suite 103
Albany, NY 12205-1002

July 1, 2009 Empire Plan Copayments for Employees of New York State Represented by CSEA

Services by Empire Plan Participating Providers

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

Office Visit $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

Outpatient Surgical Locations (including
Anesthesiology and same-day pre-operative
testing done at the center) $30

Medically appropriate local
ambulance transportation $35

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

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

Office Visit $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 *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.)

Network Hospital Outpatient Department Services

Surgery $30*

Diagnostic Laboratory Tests $30*

Diagnostic Radiology (including
mammography, according
to guidelines).....$30*

Administration of Desferal for
Cooley's Anemia $30*

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 (MRI), Magnetic Resonance Angiography (MRA); Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine tests.

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

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

Visit to Outpatient Substance Abuse Treatment Program $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 Mail Service Pharmacy

Generic Drug.....$5

Preferred Brand-Name Drug $15

Non-Preferred Brand-Name Drug.....$40**

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

Generic Drug.....$10

Preferred Brand-Name Drug $30

Non-Preferred Brand-Name Drug $70**

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

Generic Drug.....$5

Preferred Brand-Name Drug $20

Non-Preferred Brand-Name Drug.....$65**

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

Notes