January 1, 2016

At A Glance

C-82
Council 82

For Employees of the State of New York represented by Council 82 and for their enrolled Dependents; and for COBRA Enrollees and Young Adult Option Enrollees with their Empire Plan benefits

This guide briefly describes Empire Plan benefits. It is not a complete description and is subject to change. For a complete description of your benefits and your responsibilities, refer to your *Empire Plan Certificate* and all *Empire Plan Reports* and *Certificate Amendments*. For information regarding your NYSHIP eligibility or enrollment, contact your Health Benefits Administrator (HBA). If you have questions regarding specific benefits or claims, contact the appropriate Empire Plan administrator. (See page 19.)

New York State Department of Civil Service
Employee Benefits Division, Albany, NY 12239
https://www.cs.ny.gov/employee-benefits

NEW YORK STATE | The Empire Plan

WHAT'S NEW

- **In-Network Out-of-Pocket Limit –** For 2016, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan is $6,850 for Individual coverage and $13,700 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. See page 3 for more information.
- **Out-of-Network Referrals –** Effective January 1, 2016, due to provisions of the Emergency Medical Services and Surprise Bills law, you may request a referral to receive services from an out-of-network provider, if a network provider is not available within a 30-mile radius or a 30-minute travel time from your home address, or if a provider with the appropriate level of training or experience is not accessible to treat your condition. If the request is approved, your out-of-pocket costs will be the same as when you use a network provider. See the *insert* in this publication for more details.
- **The Empire Plan Mental Health and Substance Abuse Program –** Effective January 1, 2016, the Empire Plan Mental Health and Substance Abuse Program administrator, formerly known as ValueOptions, Inc., has rebranded and changed its name to Beacon Health Options, Inc. Benefits and provider networks will remain the same.
- **2016 Empire Plan Flexible Formulary Drug List –** The annual update lists the most commonly prescribed generic and brand-name drugs included in the 2016 Empire Plan Flexible Formulary and newly excluded drugs with 2016 Empire Plan Flexible Formulary alternatives.

  Please note: Due to the recent recall of Auvi-Q, the Empire Plan Prescription Drug Program will continue to cover the epinephrine auto-injectors Epi-pen and Epi-pen Jr. for 2016. The List of Excluded Drugs on the 2016 Empire Plan Flexible Formulary has been updated and is available online at https://www.cs.ny.gov/employee-benefits.

Quick Reference

The Empire Plan is a comprehensive health insurance program for New York's public employees and their families. The Plan has four main parts:

Hospital Program

administered by Empire BlueCross BlueShield

Provides coverage for inpatient and outpatient services provided by a hospital or skilled nursing facility and hospice care. Includes the Center of Excellence for Transplants Program. Also provides inpatient Benefits Management Program services, including preadmission certification of hospital admissions and admission or transfer to a skilled nursing facility, concurrent reviews, discharge planning, inpatient Medical Case Management and the Empire Plan Future Moms Program.

Medical/Surgical Program

administered by UnitedHealthcare

Provides coverage for medical services, such as office visits, surgery and diagnostic testing under the Participating Provider, Basic Medical and Basic Medical Provider Discount Programs. Coverage for physical therapy and chiropractic care is provided through the Managed Physical Medicine Program.

Also provides coverage for convenience care clinics, home care services, durable medical equipment and certain medical supplies through the Home Care Advocacy Program (HCAP); the Prosthetics/Orthotics Network; Center of Excellence Programs for Cancer and for Infertility; and Benefits Management Program services including Prospective Procedure Review for MRI, MRA, CT, PET scan, Nuclear Medicine tests, Voluntary Specialist Consultant Evaluation services and outpatient Medical Case Management.

Mental Health & Substance Abuse Program

administered by Beacon Health Options, Inc.

Provides coverage for inpatient and outpatient mental health and substance abuse services. Also provides preadmission certification of inpatient and certain outpatient services, concurrent reviews, case management and discharge planning.

Prescription Drug Program

administered by CVS/caremark

Provides coverage for prescription drugs dispensed through Empire Plan network pharmacies, the mail service pharmacy, the specialty pharmacy and non-network pharmacies.

Please see *Contact Information* on page 19 for NYSHIP addresses, teletypewriter (TTY) numbers and other important contact information.

Benefits Management Program

The Empire Plan Benefits Management Program helps to protect the enrollee and allows the Plan to continue to cover essential treatment for patients by coordinating care and avoiding unnecessary services. The Benefits Management Program precertifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient Medical Case Management. In order to receive maximum benefits under the Plan, following the Benefits Management Program requirements – including obtaining precertification for certain services – is required when The Empire Plan is your primary coverage.

YOU MUST CALL
for preadmission certification

If The Empire Plan is primary for you or your covered dependents, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program (administered by Empire BlueCross BlueShield):

- Before a scheduled (nonemergency) hospital admission, skilled nursing facility admission/transfer or transplant surgery.†
- Before a maternity hospital admission.† Call as soon as a pregnancy is certain.
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.†

If you do not call and the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.

†These services are subject to a $200 penalty if the hospitalization is determined to be medically necessary, but not precertified.

Other Benefits Management Program services provided by the Hospital Program include:

- Concurrent review of hospital inpatient treatment,
- Discharge planning for medically necessary services post-hospitalization,
- Inpatient Medical Case Management for coordination of covered services for certain catastrophic and complex cases that may require extended care, and
- The Empire Plan Future Moms Program for early risk identification.

YOU MUST CALL
for Prospective Procedure Review

If The Empire Plan is primary for you or your covered dependents, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program (administered by UnitedHealthcare) before receiving the following scheduled (nonemergency) diagnostic tests:

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computerized Tomography (CT)
- Positron Emission Tomography (PET) scan
- Nuclear Medicine test

Precertification is required unless you are having the test as an inpatient in a hospital. If you do not call, you will pay a larger part of the cost. If the test or procedure is determined not to be medically necessary, you will be responsible for the entire cost.

Other Benefits Management Program services provided by the Medical Program include:

- Coordination of Voluntary Specialist Consultant Evaluation, and
- Outpatient Medical Case Management for coordination of covered services for certain catastrophic and complex cases that may require extended care.

Be sure to review the Benefits Management Program section of your *Empire Plan Certificate* and subsequent *Certificate Amendments* for complete information on the program's services and requirements.

Out-Of-Pocket Costs

In-Network Out-of-Pocket Limit

As a result of Patient Protection and Affordable Care Act (PPACA) provisions, there is a limit on the amount you will pay out of pocket for in-network services/supplies received during the Plan year.

Out-of-Pocket Limit: The amount you pay for network services/supplies is capped at the out-of-pocket limit. Network expenses include copayments you make to providers, facilities and pharmacies (network expenses do not include premiums, deductibles or coinsurance). Once the out-of-pocket limit is reached, network benefits are paid in full.

Beginning January 1, 2016, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $4,450 for in-network expenses incurred under the Hospital Program, Medical/Surgical Program and Mental Health and Substance Abuse Program
- $2,400 for in-network expenses incurred under the Prescription Drug Program*

Family Coverage

- $8,900 for in-network expenses incurred under the Hospital Program, Medical/Surgical Program and Mental Health and Substance Abuse Program
- $4,800 for in-network expenses incurred under the Prescription Drug Program*

Does not apply to Medicare-primary enrollees or dependents. Refer to your Empire Plan Medicare Rx documents for information about your out-of-pocket expenses.

Out-of-Network Combined Annual Deductible

The combined annual deductible is $1,000 for the enrollee, $1,000 for the enrolled spouse/domestic partner and $1,000 for all dependent children combined.

The combined annual deductible must be met before Basic Medical Program expenses, non-network expenses under the Home Care Advocacy Program and outpatient non-network expenses under the Mental Health and Substance Abuse Program will be considered for reimbursement.

Combined Annual Coinsurance Maximum

The combined annual coinsurance maximum is $3,000 for the enrollee, $3,000 for the enrolled spouse/domestic partner and $3,000 for all dependent children combined.

Coinsurance amounts incurred for non-network Hospital coverage, Basic Medical Program coverage and non-network Mental Health and Substance Abuse coverage count toward the combined annual coinsurance maximum. Copayments to Medical/Surgical Program participating providers and to Mental Health and Substance Abuse Program network practitioners also count toward the combined annual coinsurance maximum. (**Note:** Copayments made to network facilities do not count toward the combined annual coinsurance maximum.)

Preventive Care Services

Your coverage is “non-grandfathered,” which means that your Empire Plan benefits reflect changes required by the federal Patient Protection and Affordable Care Act (PPACA) implementation timetable.

When you meet established criteria (such as age, gender and risk factors) for certain preventive care services, those preventive services are provided to you at no cost when you use an Empire Plan participating provider or network facility. See the *2016 Empire Plan Preventive Care Coverage Chart* for examples of covered services.

For further information on PPACA preventive care services and criteria to receive preventive care services at no cost, visit www.hhs.gov/healthcare/rights/preventive-care.

Center Of Excellence Programs

For further information on any of the programs listed below, refer to your *Empire Plan Certificate* and the publication *Reporting On Centers of Excellence*. In some cases, a travel, lodging and meal allowance may be available. If you do not use a Center of Excellence, benefits are provided in accordance with Hospital Program and/or Medical/Surgical Program coverage.

Cancer Services*

YOU MUST CALL The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program or call the Cancer Resources Center toll free at 1-866-936-6002 and register to participate

Paid-in-full benefits are available for cancer services at a designated Center of Excellence. You will also receive nurse consultations, assistance locating cancer centers and a travel allowance, when applicable.

Transplants Program

YOU MUST CALL The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program for prior authorization

Paid-in-full benefits are available for the following transplant services when authorized by the Hospital Program and received at a designated Center of Excellence: pretransplant evaluation of transplant recipient; inpatient and outpatient hospital and physician services; and up to 12 months of follow-up care.

You must call The Empire Plan for preauthorization of the following transplants provided through the Center of Excellence for Transplants Program: bone marrow; cord blood stem cell; heart; heart-lung; kidney; liver; lung; pancreas; pancreas after kidney; peripheral stem cell; and simultaneous kidney/pancreas. When applicable, a travel allowance is available.

If you choose to have your transplant in a facility other than a designated Center of Excellence (or if you require a small bowel or multivisceral transplant) you may still take advantage of the Hospital Program case management services, in which a nurse will help you through the transplant process, if you enroll in the Center of Excellence for Transplants Program. If a transplant is authorized but you do not use a designated Center of Excellence, benefits will be provided in accordance with Hospital and/or Medical/Surgical Program coverage. **Note:** Transplant surgery preauthorization is required whether or not you choose to participate in the Center of Excellence for Transplants Program.

To enroll in the Program and receive these benefits, The Empire Plan must be your primary coverage.

Infertility Benefits*

YOU MUST CALL The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program for prior authorization

Paid-in-full benefits are available, subject to the lifetime maximum for Qualified Procedures ($50,000 per covered person) including any applicable travel allowance, when you choose a Center of Excellence for Infertility and receive prior authorization. To request a list of Qualified Procedures, or for preauthorization of infertility benefits, call the Medical/Surgical Program.

Center of Excellence Program Travel Allowance

When you are enrolled in the Center of Excellence Program or use a Center of Excellence for preauthorized infertility services, a travel, lodging and meal expenses benefit is available for travel within the United States. The benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, the benefit will include coverage for up to two companions. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage

**Program requirements apply even if Medicare or another health plan is primary to The Empire Plan.*

will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. Once you arrive at your lodging and need transportation from your lodging to the Center, certain costs of local travel are also reimbursable, including local subway, taxi or bus fare; shuttle, parking and tolls.

Hospital Program

PRESS OR SAY 2 **Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 2 to reach the Hospital Program.**

The Hospital Program provides benefits for services provided in a network or non-network inpatient or outpatient hospital, skilled nursing facility or hospice setting. Services and supplies must be covered and medically necessary, as defined in the current version of your *Empire Plan Certificate* or as amended in subsequent *Empire Plan Reports*. The Medical/Surgical Program provides benefits for certain medical and surgical care when it is not covered by the Hospital Program.

Call the Hospital Program for preadmission certification or if you have questions about your benefits, coverage or an Explanation of Benefits (EOB) Statement.

Network coverage applies when you receive emergency or urgent services in a non-network hospital, or when you use a non-network hospital because you do not have access to a network hospital. Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Network Coverage

You pay only applicable copayments for services/supplies provided by a hospital, skilled nursing facility or hospice that is part of The Empire Plan network. No deductible or coinsurance applies. Network coverage also applies when The Empire Plan provides coverage that is secondary to other coverage.

Non-network Coverage

When you use a facility that is not part of The Empire Plan network and do not qualify for network coverage (see above), your out-of-pocket costs are higher.

- You are responsible for a coinsurance amount of 10 percent of billed charges for inpatient facility services until you meet the combined annual coinsurance maximum.
- You are responsible for a coinsurance amount of 10 percent of billed charges or a $75 copayment, whichever is greater, for outpatient services until you meet the combined annual coinsurance maximum.

Hospital Inpatient

YOU MUST CALL
for preadmission certification. See page 2.

The Hospital Program covers you for a combined maximum of up to 365 days per spell of illness for inpatient diagnostic and therapeutic services or surgical care provided by a network and/or non-network hospital. Inpatient hospital coverage is provided under the Medical/Surgical Program's Basic Medical Program after Hospital Program benefits end.

Network Coverage

Inpatient stays in a network hospital are paid in full.

Non-network Coverage

Inpatient stays in a non-network hospital are subject to a coinsurance amount of 10 percent of billed charges, until you meet the combined annual coinsurance maximum. See page 3. Network coverage is provided once the combined annual coinsurance maximum is satisfied.

Hospital Outpatient

Emergency Department

Network Coverage

You pay one $70 copayment per visit to an Emergency Department, including use of the facility for emergency care, services of the attending physician, services of providers who administer or interpret laboratory tests and electrocardiogram services. Other physician charges are covered under the Medical/Surgical Program. See page 7.

The copayment is waived if you are admitted as an inpatient directly from the Emergency Department.

Non-network Coverage

Network coverage applies to emergency services received in a non-network hospital.

Outpatient Department or Hospital Extension Clinic

The hospital outpatient services covered under the Program are the same whether received in a network or non-network hospital outpatient department or in a network or non-network hospital extension clinic. The following benefits apply to services received in the outpatient department of a hospital or a hospital extension clinic.

Network Coverage

Outpatient surgery is subject to a $60 copayment.

You pay one $40 copayment per visit for diagnostic radiology, diagnostic laboratory tests and/or administration of Desferal for Cooley's Anemia.

You have paid-in-full benefits for:

- preadmission and/or presurgical testing prior to an inpatient admission
- chemotherapy
- radiation therapy
- anesthesiology
- pathology
- dialysis

The following services are paid in full when designated preventive according to the Patient Protection and Affordable Care Act:

- bone mineral density tests
- colonoscopies
- mammograms
- pap smears
- proctosigmoidoscopy screenings
- sigmoidoscopy screenings

Physical therapy following a related hospitalization or related inpatient or outpatient surgery is subject to a $20 copayment per visit. Physical therapy must start within six months from your discharge from the hospital or the date of your outpatient surgery and be completed within 365 days from the date of hospital discharge or outpatient surgery.

Non-network Coverage

You are responsible for a coinsurance amount of 10 percent of billed charges or a $75 copayment (whichever is greater) per visit, until you meet the combined annual coinsurance maximum. See page 3. Network coverage is provided once the combined annual coinsurance maximum is satisfied.

Medically necessary physical therapy is covered under the Managed Physical Medicine Program when not covered under the Hospital Program. See page 12.

Skilled Nursing Facility Care

YOU MUST CALL
for preadmission certification. See page 2.

Benefits are subject to the requirements of the Empire Plan Benefits Management Program if The Empire Plan provides your primary health coverage.

Network Coverage

Skilled nursing facility care is paid in full when provided in place of hospitalization. Limitations apply; refer to your *Empire Plan Certificate* regarding conditions of coverage.

Non-network Coverage

Skilled nursing facility care is covered when provided in place of hospitalization. You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum. Network coverage is provided once the combined annual coinsurance maximum is satisfied. See page 3.

Hospice Care

Network Coverage

Care provided by a licensed hospice program is paid in full. Refer to your *Empire Plan Certificate* regarding conditions of coverage.

Non-network Coverage

You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum, for care provided by a licensed hospice program. Network coverage is provided once the combined annual coinsurance maximum is satisfied. See page 3.

Medical/Surgical Program Benefits for Physician/Provider Services Received in a Hospital Inpatient or Outpatient Setting, Skilled Nursing Facility or Hospice Setting

When you receive covered services from a physician or other provider in a hospital, skilled nursing facility or hospice setting and those services are billed by the provider (not the facility), the following Medical/Surgical benefits apply:

Participating Provider Program

Covered services are paid in full when the provider participates in The Empire Plan network.

Basic Medical Program

Covered radiology, anesthesiology and pathology services received in a network facility are paid in full when the provider does not participate in The Empire Plan network and The Empire Plan is your primary coverage. Services provided by other nonparticipating providers are subject to deductible and coinsurance.

Emergency care in a hospital Emergency Department is covered as follows:

- an attending Emergency Department physician is paid in full
- evaluation and management emergency care billed by an attending Emergency Department physician is paid in full
- participating or nonparticipating providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams and/or pathology are paid in full
- other participating providers are paid in full
- other nonparticipating providers (e.g. surgeons) are considered under the Basic Medical Program and are not subject to deductible and coinsurance

New Patient Protections – *The Emergency Medical Services and Surprise Bills* law provides additional protections to limit out-of-pocket expenses for patients who receive services from nonparticipating (non-network) providers without their knowledge. Contact the Medical Program for more information.

Medical/Surgical Program

PRESS OR SAY 1 **Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 1 to reach the Medical/Surgical Program.**

The Medical/Surgical Program covers services received from a physician or other practitioner licensed to provide medical/surgical services. It also covers services received from facilities not covered under the Hospital Program, such as outpatient surgical centers, imaging centers, laboratories, cardiac rehabilitation centers, urgent care centers and convenience care clinics. Services and supplies must be covered and medically necessary, as defined in the current version of your *Empire Plan Certificate* or as amended in subsequent *Empire Plan Reports.* Call the Medical/Surgical Program if you have questions about coverage, benefits or the status of a provider.

Participating Provider Program

The Participating Provider Program provides medical/surgical benefits for services/supplies received from a provider that participates in The Empire Plan network.

When you receive covered services from a participating provider, you pay only applicable copayments. Women's health care services, many preventive care services and certain other covered services are paid in full. See pages 9-11.

The Plan does not guarantee that participating providers are available in all specialties or geographic locations.

Guaranteed Access

The Empire Plan will guarantee access to Participating Provider Program benefits for primary care providers and certain specialists when there are no Empire Plan participating providers within a reasonable distance from the enrollee's residence (see below). This benefit is available in New York State and counties in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont that share a border with New York State. To receive this benefit:

- The Empire Plan must provide your primary health coverage (pays first, before another health plan or Medicare).
- You must contact the Medical Program prior to receiving services and use one of the providers approved by the Program.
- You must contact the provider to arrange care. Appointments are subject to provider's availability and the Program does not guarantee that a provider will be available in a specified time period.

Reasonable distance from the enrollee's residence is defined by the following mileage standards:

Primary Care
Urban: 8 miles
Suburban: 15 miles
Rural: 25 miles

Specialist
Urban: 15 miles
Suburban: 25 miles
Rural: 50 miles

Network benefits are guaranteed for the following primary care providers and core specialties, within the mileage standards specified above:

Primary Care Providers	***Specialties***	***Specialties Continued***
Family Practice	Allergy	Neurology
General Practice	Anesthesia	Ophthalmology
Internal Medicine	Cardiology	Orthopedic Surgery
Pediatrics	Dermatology	Otolaryngology
Obstetrics/Gynecology	Emergency Medicine	Pulmonary Medicine
	Gastroenterology	Radiology
	General Surgery	Rheumatology
	Hematology/Oncology	Urology

Basic Medical Program

The Basic Medical Program provides benefits for services/supplies received from a provider that does not participate in The Empire Plan network.

Your out-of-pocket costs are higher when you use a provider that does not participate in The Empire Plan network.

Combined Annual Deductible: The combined annual deductible must be satisfied before The Empire Plan pays benefits. See page 3.

Coinsurance: The Empire Plan pays 80 percent of the usual and customary rate for covered services after you meet the combined annual deductible. You are responsible for the balance.

Combined Annual Coinsurance Maximum: After the combined annual coinsurance maximum is reached, The Empire Plan pays 100 percent of the usual and customary rate for covered services. See page 3.

Usual and Customary Rate (formerly known as Reasonable and Customary Charge): The lowest of the actual charge, the provider's usual charge or the usual charge within the same geographic area. The Empire Plan generally utilizes FAIR Health© rates at the 90th percentile to determine the allowable amount. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the usual and customary rate for these services in your geographic area or zip code.

Basic Medical Provider Discount Program

If The Empire Plan is your primary insurance coverage and you use a nonparticipating provider who is part of The Empire Plan MultiPlan group, your out-of-pocket expense will, in most cases, be reduced. Your share of the cost will be based on the lesser of The Empire Plan MultiPlan fee schedule or the usual and customary rate.

The Empire Plan MultiPlan provider will submit bills to and receive payments directly from UnitedHealthcare. You are only responsible for the applicable deductible and coinsurance amounts. To find a provider, call the Medical Program or visit https://www.cs.ny.gov/employee-benefits.

Office Visit/Office Surgery; Laboratory/Radiology; Contraceptives

Participating Provider Program

Office visits, including office surgery, may be subject to a single $20 copayment per visit. A single, separate $20 copayment may apply to laboratory services, radiology services and/or certain immunizations provided during the office visit. Certain contraceptives may be subject to a separate $20 copayment.

Certain visits and laboratory/radiology services are not subject to copayment, including well-child care, prenatal care and visits for preventive care and women's health care.

Basic Medical Program

Covered services provided by or received from a non-participating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Routine Health Exams

Participating Provider Program

Preventive routine health exams are paid in full.

Other covered services received during a routine health exam may be subject to copayment(s).

Basic Medical Program

Routine health exams are covered for active employees age 40 or older and for an active employee's spouse/domestic partner age 40 or older. This benefit is not subject to deductible or coinsurance. Covered services, such as laboratory tests and screenings provided during a routine exam that fall outside the scope of a routine exam, are subject to deductible and coinsurance. For further information, contact the Medical Program.

Adult Immunizations

Participating Provider Program

The following adult immunizations are paid in full based on recommendations by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Other immunizations may have a $20 copayment.

- Influenza (flu)*
- Pneumococcal (pneumonia)*
- Measles, Mumps, Rubella (MMR)
- Varicella (chickenpox)
- Tetanus, Diphtheria, Pertussis (Td/Tdap)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV), if the recipient is age 19 through 26
- Meningococcal (meningitis)*
- Herpes Zoster (Shingles),* if the recipient is age 60 or older (**Note:** this immunization is covered for enrollees age 55 to 59, subject to a $20 copayment.)

** Vaccines indicated with an asterisk are also paid in full under the Prescription Drug Program at pharmacies that participate in CVS/caremark's national vaccine network. Other vaccines are not covered when received in a pharmacy setting. Refer to page 18 for information.*

Basic Medical Program

Not covered.

Routine Pediatric Care • *Up to age 19*

Participating Provider Program

Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and the cost of oral and injectable substances (including the influenza vaccine) when administered according to pediatric immunization guidelines.

Basic Medical Program

Routine Newborn Child Care: Provider services for routine care of a newborn child are covered and not subject to deductible or coinsurance.

Routine Pediatric Care: Routine pediatric care rendered by a nonparticipating provider is subject to Basic Medical Program benefits, including deductible and coinsurance.

Outpatient Surgical Locations

Participating Provider Program

A $30 copayment covers facility, same-day on-site testing, laboratory services provided on-site and anesthesiology charges for covered services at a participating surgical center.

Basic Medical Program

Covered services provided by a nonparticipating outpatient surgical center are subject to Basic Medical Program benefits, including deductible and coinsurance. The allowed amount will be a facility rate based on information provided by a third-party vendor. This allowable generally equates to 232 percent of FAIR Health© Usual and Customary facility rates.*

Hospital and hospital-based Outpatient Surgical Locations are covered under the Hospital Program. See *Outpatient Department or Hospital Extension Clinic*, page 6.

**Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Diabetes Education Centers

Participating Provider Program

Visits to a Diabetes Education Center are subject to a $20 copayment.

To find an Empire Plan-participating Diabetes Education Center, call the Medical Program or visit our web site at https://www.cs.ny.gov/employee-benefits. Select Find a Provider and then The Empire Plan Medical/Surgical Provider Directory.

Basic Medical Program

Visits to a nonparticipating Diabetes Education Center are subject to Basic Medical Program benefits, including deductible and coinsurance.

Prostheses and Orthotic Devices

Participating Provider Program

Prostheses/orthotic devices that meet the individual's functional needs are paid in full when obtained from a participating provider.

Basic Medical Program

Prostheses/orthotic devices that meet the individual's functional needs are subject to Basic Medical Program benefits, including deductible and coinsurance.

Hearing Aids

Basic Medical Program

Hearing aid evaluation, fitting and purchase of hearing aids is covered under the Basic Medical Program, up to a maximum reimbursement of $1,500 per hearing aid, per ear, once every four years. Children age 12 and under are covered up to $1,500 per hearing aid, per ear, once every two years if the existing hearing aid can no longer compensate for the child's hearing loss. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

Wigs

Basic Medical Program

Wigs are covered under the Basic Medical Program benefit, up to a $1,500 lifetime maximum, when hair loss is due to a chronic or acute medical condition. This benefit applies whether you use a participating or non-participating provider and is not subject to deductible or coinsurance.

External Mastectomy Prostheses

Basic Medical Program

One single or double external mastectomy prosthesis is covered under the Basic Medical Program, once per calendar year. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

You must call the Medical Program and select the Benefits Management Program for precertification of any single prosthesis costing $1,000 or more. For a prosthesis requiring prior approval, benefits will be available for the most cost-effective prosthesis that meets an individual's functional needs.

Emergency Ambulance Service

Basic Medical Program

Local commercial ambulance charges are covered except the first $35. When the enrollee has no obligation to pay, donations up to $50 for trips of fewer than 50 miles and up to $75 for trips over 50 miles will be reimbursed for voluntary ambulance services. This benefit applies whether you use an ambulance service that is a participating provider or a nonparticipating provider and is not subject to deductible or coinsurance.

Managed Physical Medicine Program

Administered by Managed Physical Network (MPN)

Chiropractic Treatment, Physical Therapy and Occupational Therapy

Network Coverage *(when you use MPN)*

Each office visit to an MPN provider is subject to a $20 copayment. Related radiology and diagnostic laboratory services billed by the MPN provider are subject to a separate $20 copayment. No more than two copayments per visit will be assessed.

MPN guarantees access to network benefits. If there are no network providers in your area, you must contact MPN prior to receiving services to arrange for network benefits.

Non-network Coverage *(when you don't use MPN)*

Annual Deductible: $250 enrollee; $250 enrolled spouse/domestic partner; $250 all dependent children combined. This deductible is separate from the combined annual deductible.

Coinsurance: The Empire Plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum. Coinsurance under the Managed Physical Medicine Program does not contribute to and is separate from the combined annual coinsurance maximum. The network allowance generally equates to 12 percent of FAIR Health© Usual and Customary professional rates.*

Home Care Advocacy Program (HCAP)

Home Care Services, Skilled Nursing Services and Durable Medical Equipment/Supplies

YOU MUST CALL
for prior authorization

Network Coverage *(when you use HCAP)*

To receive a paid-in-full benefit, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program, then Benefits Management Program, to precertify and help make arrangements for covered services, durable medical equipment and supplies, including one pair of diabetic shoes per year, insulin pumps, Medijectors and enteral formulas. Diabetic shoes have an annual maximum benefit of $500.

Exceptions: For diabetic supplies (except insulin pumps and Medijectors), call The Empire Plan Diabetic Supplies Pharmacy at 1-888-306-7337. For ostomy supplies, call Byram Healthcare Centers at 1-800-354-4054.

Non-network Coverage *(when you don't use HCAP)*

The first 48 hours of nursing care are not covered. After you meet the combined annual deductible (see page 3), The Empire Plan pays up to 50 percent of the HCAP network allowance for covered services, durable medical equipment and supplies. There is no coinsurance maximum. You are also covered for one pair of diabetic shoes per year that are paid up to 75 percent of the HCAP network allowance with a $500 annual maximum. The network allowance generally equates to 43 percent of FAIR Health© Usual and Customary professional rates.*

Important: If Medicare is your primary coverage, and you do not use a Medicare contract provider, your benefits will be reduced. If Medicare is your primary coverage and you live in an area or need supplies while visiting an area that participates in the Medicare Durable Medical Equipment, Prosthetics and Orthotics Supply (DMEPOS) Competitive Bidding Program, you must use a Medicare-approved supplier. All of New York State is affected by DMEPOS. To locate a Medicare contract supplier, visit www.medicare.gov/supplierdirectory or contact The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program, then Benefits Management Program/Home Care Advocacy Program.

**Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Mental Health And Substance Abuse Program

PRESS OR SAY 3 **For the highest level of benefits, call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 3 to reach the Mental Health and Substance Abuse Program.**

Call the Mental Health and Substance Abuse Program before seeking certain services from a mental health or substance abuse provider, including treatment for alcoholism. The Clinical Referral Line is available 24 hours a day, every day of the year. You will receive the highest level of benefits when you follow the Program requirements for network coverage. You have guaranteed access to network benefits if you contact the Mental Health and Substance Abuse Program before you receive services. In an emergency, go to the nearest hospital Emergency Department. You or your designee should call the Mental Health and Substance Abuse Program within 48 hours of an admission for emergency care or as soon as reasonably possible.

Network Coverage

You pay only applicable copayments for covered services provided by a provider or facility that is in The Empire Plan network. No deductible or coinsurance applies.

Non-network Coverage

When you use a provider or facility that is not in The Empire Plan network, your out-of-pocket costs are higher, as described in this section.

Inpatient Services

You should call before an admission to a Mental Health or Substance Abuse facility to ensure that benefits are available. In the case of an emergency admission, certification should be requested as soon as possible. Network facilities are responsible for obtaining precertification. If you use a non-network facility, you may be required to pay the full cost of any stay determined not to be medically necessary.

Network Coverage	Non-network Coverage
Inpatient stays in an approved network facility are paid in full.	You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum. See page 3. When the combined annual coinsurance maximum is met, you will receive network benefits.
Practitioner Treatment or Consultation: Covered treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner – not the facility – are paid in full.	**Practitioner Treatment or Consultation:** Covered treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner – not the facility – are subject to deductible and coinsurance as described under *Office Visits and other Outpatient Services*, page 14.

Ambulance Service

Ambulance service to a facility where you will be receiving mental health or substance abuse care is covered when medically necessary.

Outpatient Services

Hospital Emergency Department

Network Coverage

You pay one $70 copayment per visit to an Emergency Department. The copayment is waived if you are admitted as an inpatient directly from the Emergency Department.

Non-network Coverage

Network coverage applies to Emergency Department visits at a non-network hospital.

Office Visits and other Outpatient Services

Network Coverage

Office visits and other outpatient services, such as outpatient substance abuse rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a $20 copayment per visit. Up to three visits per crisis are paid in full for mental health treatment. After the third visit, the $20 copayment per visit applies.

Non-network Coverage

Combined Annual Deductible: The combined annual deductible must be satisfied before The Empire Plan pays benefits. See page 3.

Coinsurance: The Empire Plan pays 80 percent of the usual and customary rate for covered services after you meet the combined annual deductible. You are responsible for the balance.

Combined Annual Coinsurance Maximum: After the combined annual coinsurance maximum is reached, The Empire Plan pays benefits for covered services at 100 percent of the usual and customary rate. See page 3.

Usual and Customary Rate (formerly known as Reasonable and Customary Charge): The lowest of the actual charge, the provider's usual charge or the usual charge within the same geographic area. The Empire Plan generally utilizes FAIR Health© rates at the 90th percentile to determine the allowable amount. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the usual and customary rate for these services in your geographic area or zip code.

YOU MUST CALL
for precertification

Psychological Testing or Evaluation, Electroconvulsive Therapy, Applied Behavior Analysis Services

Precertification to confirm medical necessity is required before beginning psychological testing or evaluations, electroconvulsive therapy or Applied Behavior Analysis for the treatment of autism spectrum disorder.

Neuropsychological Testing

Neuropsychological testing and evaluations for mental health or substance abuse diagnosis in a network or non-network setting will be reviewed for medical necessity. Only medically necessary services are covered; therefore, precertification by the Mental Health and Substance Abuse Program is recommended before testing or evaluation begins.

Notes: Neuropsychological testing with a medical diagnosis is also covered under the Medical Program. These services will be reviewed by UnitedHealthcare for medical necessity. Precertification by UnitedHealthcare is recommended before testing or evaluation begins.

Prescription Drug Program

PRESS OR SAY 4 **Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 4 to reach the Prescription Drug Program.**

The Prescription Drug Program provides coverage for prescriptions for covered drugs, up to a 90-day supply, when filled at network, mail service, specialty and non-network pharmacies.

Copayments

You have the following copayments for covered drugs purchased from a Network Pharmacy, the Mail Service Pharmacy or a Specialty Pharmacy.

Up to a 30-day supply from a Network Pharmacy, the Mail Service Pharmacy, or Specialty Pharmacy	**31- to 90-day supply from a Network Pharmacy**	**31- to 90-day supply from the Mail Service Pharmacy or Specialty Pharmacy**
Level 1 Drugs or for most **Generic** Drugs $5	Level 1 Drugs or for most **Generic** Drugs $10	Level 1 Drugs or for most **Generic** Drugs $5
Level 2, **Preferred** Drugs or Compound Drugs $25	Level 2, **Preferred** Drugs or Compound Drugs $50	Level 2, **Preferred Drugs** or Compound Drugs $50
Level 3 or **Non-preferred** Drugs $45	Level 3 or **Non-preferred** Drugs $90	Level 3 or **Non-preferred** Drugs $90

Drugs not Subject to Copayment

Certain covered drugs do not require a copayment when using a Network Pharmacy:

- oral chemotherapy drugs, when prescribed for the treatment of cancer
- generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices)*
- Tamoxifen and Raloxifene, when prescribed for the primary prevention of breast cancer*
- Certain preventive adult vaccines when administered by a licensed pharmacist

**Copayment waivers for these drugs only will be provided if the drug is filled at a Network Pharmacy.*

Brand-Name Drugs with Generic Equivalent

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the Level 3 Non-preferred drug copayment plus the ancillary charge, not to exceed the full retail cost of the covered drug.

Ancillary Charge: The difference in cost between the brand-name drug and the generic equivalent.

Exceptions

- If the brand-name drug has been placed on Level 1 of The Empire Plan Flexible Formulary, you will pay the Level 1 copayment.
- You pay only the applicable copayment for the following Level 3 brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. One copayment covers up to a 90-day supply.

New to You Prescriptions Program: Certain maintenance medications require at least two 30-day supplies to be filled using your Empire Plan Prescription Drug Program benefits before a supply for greater than 30 days will be covered. If you attempt to fill a prescription for a maintenance medication for more than a 30-day supply at a Network or Mail Service Pharmacy, the last 180 days of your prescription history will be reviewed to determine whether at least 60 days' worth of the drug has been previously dispensed. If not, only a 30-day fill will be approved. **Note:** If your drug is pre-packed in a 28-day supply, you will need to have at least two 28-day supplies in the past 180 days in order to meet the New to You requirement.

Flexible Formulary Drug List

The Empire Plan Prescription Drug Program has a Flexible Formulary drug list for prescription drugs. The Empire Plan Flexible Formulary is designed to provide enrollees and the Plan with the best value in prescription drug spending.

This is accomplished by:

- Excluding coverage for certain brand-name or generic drugs if the drug has no clinical advantage over other covered medications in the same therapeutic class.
- Placing a brand-name drug on Level 1 or excluding or placing a generic drug on Level 3, subject to the appropriate copayment. These placements may be revised mid-year when such changes are advantageous to The Empire Plan. Enrollees will be notified in advance of such changes.
- Applying the highest copayment to non-preferred drugs that provide no clinical advantage over two or more Level 1 drug alternatives in the same therapeutic class. This may result in no Level 2 brand-name drugs.

Prior Authorization Required

You must have prior authorization for the following drugs, including generic equivalents:

- Abstral
- Actemra
- Acthar HP
- Actimmune
- Actiq
- Adagen
- Adcirca
- Adempas
- Aldurazyme
- Alferon-N
- Ampyra
- Apokyn
- Aralast
- Aranesp
- Arcalyst
- Aubagio
- Aveed
- Avonex
- Benlysta
- Berinert
- Bethkis
- Bivigam
- Botox
- Buphenyl
- Carbaglu
- Cayston
- Cerdelga
- Cerezyme
- Cimzia
- Cinryze
- Cosentyx
- Cystagon
- Cystaran
- Copaxone
- Daklinza
- deferoxamine (Desferal)
- Dysport
- Eligard
- Egrifta
- Enbrel
- Elaprase
- Elelyso
- Entyvio
- Epogen/Procrit
- Esbriet
- Exjade
- Extavia
- Fabrazyme
- Fentora
- Ferriprox
- Firazyr
- Firmagon
- Flolan
- Forteo
- Fuzeon
- Gattex
- Gilenya
- Glassia
- Granix
- Growth Hormones
- Harvoni
- Hetlioz
- Humira
- Hyqvia
- Ilaris
- Immune Globulins
- Increlex
- Infergen
- Intron A
- Jadenu
- Juxtapid
- Kalbitor
- Kalydeco
- Kineret
- Korlym
- Krystexxa
- Kuvan
- Kynamro
- Lamisil
- Lazanda
- Lemtrada
- Letairis
- Leukine
- leuprolide
- Lumizyme
- Lupaneta Pack
- Lupron Depot
- Lupron Depot-Ped
- Makena
- modafanil
- Mozobil
- Myalept
- Myobloc
- Myozyme
- Naglazyme
- Natpara
- Neulasta
- Neumega
- Neupogen
- Northera
- Nplate
- Nuvigil
- octreotide
- Ofev
- Olysio
- Onmel
- Onsolis
- Opsumit
- Orencia
- Orenitram
- Orfadin
- Orkambi
- Otezla
- Otrexup
- Pegasys
- PegIntron
- Plegridy
- Praluent
- Prialt
- Procysbi
- Prolastin-C
- Prolia
- Promacta
- Pulmozyme
- Rasuvo
- Ravicti
- Rebif
- Remicade
- Remodulin
- Repatha
- Revatio
- Ribavirin
- Ruconest
- Sabril
- Samsca
- Sandostatin LAR
- Saxenda
- Sensipar
- Serostim
- Signifor
- Simponi
- Soliris
- Somatuline Depot
- Somavert
- Sovaldi
- Sporanox

- Stelara
- Subsys
- Supprelin LA
- Synagis
- Tazorac
- Tecfidera
- Technivie
- Tikosyn
- Tobi Podhaler
- tobramycin inhalation solution (TOBI)
- Tracleer
- Trelstar
- Tysabri
- Tyvaso
- Vantus
- Veletri
- Ventavis
- Victrelis
- Viekira Pak
- Vimizim
- Vivitrol
- VPRIV
- Weight Loss Drugs
- Xeljanz
- Xenazine
- Xeomin
- Xolair
- Xyrem
- Zavesca
- Zemaira
- Zoladex
- zoledronic acid (Reclast)

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization. **The previous list of drugs is subject to change as drugs are approved by the Food and Drug Administration, introduced into the market or approved for additional indications.** For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program. Or, visit our web site, and select Using Your Benefits and then Drugs that Require Prior Authorization.

Excluded Drugs

Certain brand-name and generic drugs are excluded from The Empire Plan Flexible Formulary if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2016 Empire Plan Flexible Formulary drug list includes drugs that are excluded in 2016, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. Check the web site for current information regarding exclusions of newly launched prescription drugs.

Newly Excluded Drugs for 2016

- Adrenaclick
- Afrezza
- Carac
- Cosopt PF
- Euflexxa
- Fabior
- Monovisc
- Onexton
- Orthovisc
- Proair Respiclick
- Proventil HFA
- Synvisc
- Synvisc-One
- Ventolin HFA
- Xopenex HFA

Medical Exception Process for Excluded Drugs

A medical exception process* is available for non-formulary drugs that are excluded from coverage.

To request a medical exception, you and your physician must first evaluate whether covered drugs on the Flexible Formulary are appropriate alternatives for your treatment. After an appropriate trial of formulary alternatives, your physician may submit a letter of medical necessity to CVS/caremark that details the formulary alternative trials and any other clinical documentation supporting medical necessity. The physician can fax the exception request to CVS/caremark at 1-888-487-9257.

If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment (and ancillary charge, if applicable) will apply for brand-name drugs.

Note: Drugs that are only FDA approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

**If you are Medicare primary, refer to your Empire Plan Medicare Rx plan materials for information regarding your appeal rights and the process to follow.*

Types of Pharmacies

Network Pharmacy

A Network Pharmacy is a retail pharmacy that participates in the CVS/caremark network. When you visit a Network Pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail Network Pharmacy location that participates in the CVS/caremark network, call the Prescription Drug Program or visit our web site and select Find a Provider.

CVS/caremark National Vaccine Network Pharmacy

Select preventive vaccines are covered without copayment when administered at a pharmacy that participates in the CVS/caremark national vaccine network. Vaccines available in a pharmacy are:

- Influenza (flu)
- Pneumococcal (pneumonia)
- Meningococcal (meningitis)
- Herpes Zoster (shingles)* – *requires prescription*

To find out if a pharmacy participates in the CVS/caremark national vaccine network, call the Prescription Drug Program or visit EmpirePlanRxProgram.com and select CVS/caremark, then Locate a Pharmacy and Pharmacy locator. Be sure to select "Vaccine network" under "Advanced Search." Only certain pharmacies are part of the CVS/caremark national vaccine network. New York State law restricts pharmacists to administering vaccines to patients age 18 or older. Similar laws may be in place in other states.

**The Herpes Zoster vaccine is only preventive (no copayment) for individuals age 60 and older. (Note: this immunization is covered for enrollees age 55 through 59, subject to a $5 copayment.)*

Call the pharmacy in advance to verify availability of the vaccine.

Mail Service Pharmacy

You may fill your prescription by mail through the CVS/caremark Mail Service Pharmacy by using the mail order form. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone or download forms at https://www.cs.ny.gov/employee-benefits. Choose your group and plan, if prompted. Click on Forms on the homepage, and scroll down to the CVS/caremark Mail Service Order Form.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services including:

- refill reminder calls
- expedited, scheduled delivery of your medications at no additional charge
- all necessary supplies, such as needles and syringes applicable to the medication
- disease education
- drug education
- compliance management
- side-effect management
- safety management

Prior authorization is required for some specialty medications. Specialty medications must be ordered through the Specialty Pharmacy Program using the CVS/caremark Mail Service Order Form. To request mail order forms or refills, or to speak to a specialty-trained pharmacist or nurse 24 hours a day, seven days a week regarding the Specialty Pharmacy Program, call the Prescription Drug Program and ask to speak with Specialty Customer Care.

A complete list of specialty medications included in the Specialty Pharmacy Program is available at https://www.cs.ny.gov/employee-benefits. Choose your group and plan (if prompted) and from the homepage, click on Using Your Benefits, then Specialty Pharmacy Drug List.

Non-Network Pharmacy

If you do not use a Network Pharmacy, or if you do not use your Empire Plan benefit card at a Network Pharmacy, you must submit a claim for reimbursement to:

The Empire Plan Prescription Drug Program
c/o CVS/caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

In most cases, you will not be reimbursed the total amount you paid for the prescription.

- If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the Program would reimburse a network pharmacy for that prescription.
- If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the program would reimburse a network pharmacy for filling the prescription with that drug's generic equivalent, unless the brand-name drug has been placed on Level 1 of The Empire Plan Flexible Formulary.

Contact Information

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program.

PRESS OR SAY 1	**Medical/Surgical Program: *Administered by UnitedHealthcare*** Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time. TTY: 1-888-697-9054 P.O. Box 1600, Kingston, NY 12402-1600 Claims submission fax: 845-336-7716 online: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Empire BlueCross BlueShield*** Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans. Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern time. TTY: 1-800-241-6894 New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 Claims submission fax: 888-367-9788 online: www.empireblue.com
PRESS OR SAY 3	**Mental Health and Substance Abuse Program: *Administered by Beacon Health Options, Inc.*** Representatives are available 24 hours a day, seven days a week. TTY: 1-855-643-1476 P.O. Box 1800, Latham, NY 12110 Claims submission fax: 855-378-8309 online: https://ets.valueoptions.com/OnlineClaimSubmission
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS/caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 1-800-863-5488 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590
PRESS OR SAY 5	**Empire Plan NurseLine℠: *Administered by UnitedHealthcare*** Registered nurses are available 24 hours a day, seven days a week to answer health-related questions. For recorded messages on more than 1,000 topics in the Health Information Library, enter PIN number 335, then say one or two words about the information you are looking for or enter a four-digit topic code from The Empire Plan NurseLine brochure. If you do not have your brochure, ask the NurseLine to send you one.

Benefits On The Web

NYSHIP Online is a complete resource for your health insurance benefits, including:

- Current publications describing your benefits and plan,
- Option Transfer materials, including a Plan Comparison Tool for NYSHIP options,
- Announcements,
- An event calendar,
- Prescription drug information,
- Contact information, and
- Links to each Empire Plan program administrator web site, which each include a current list of providers.

To find the most up-to-date information about your health insurance coverage, visit NYSHIP Online at https://www.cs.ny.gov/employee-benefits. Choose your group and plan to get to the NYSHIP Online homepage. You can bookmark this page to bypass the login screen.

This document provides a brief look at Empire Plan benefits for enrollees represented by Council 82. Use it with your *NYSHIP General Information Book & Empire Plan Certificate*, *Empire Plan Reports* and *Certificate Amendments*. If you have questions, call *1-877-7-NYSHIP (1-877-769-7447)* and choose the program you need.

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

518-457-5754 or 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
https://www.cs.ny.gov

The *Empire Plan At A Glance* is published by the Employee Benefits Division of the New York State Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits through The Empire Plan.

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Information for the Enrollee, Enrolled Spouse/
Domestic Partner and Other Enrolled Dependents

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Please do not send mail or correspondence to the return address above. See boxed address page 19.

It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on NYSHIP Online at https://www.cs.ny.gov/employee-benefits. Visit NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS agency web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

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The Empire Plan Copayments At A Glance

The listed copayments apply when services are received under the Participating Provider Program or network coverage. Preventive care services under PPACA, women's health care services and certain other covered services are not subject to copayment.

Medical/Surgical Program	$20 Copayment – Office Visit, Office Surgery, Radiology (including Diagnostic Mammography), Diagnostic Laboratory Tests, Freestanding Cardiac Rehabilitation Center Visit, Urgent Care Center Visit, Convenience Care Clinic Visit $30 Copayment – Non-hospital Outpatient Surgical Locations $35 Copayment – Professional Ambulance Transportation **Chiropractic Treatment or Physical Therapy Services (Managed Physical Medicine Program)** $20 Copayment – Office Visit, Radiology, Diagnostic Laboratory Tests
Hospital Program	$20 Copayment – Outpatient Physical Therapy $40 Copayment – Outpatient Services for Diagnostic Radiology, Diagnostic Laboratory Tests, Diagnostic Mammography Screening or Administration of Desferal for Cooley's Anemia in a Network Hospital or Hospital Extension Clinic $60 Copayment – Outpatient Surgery $70 Copayment – Emergency Department Visit
Mental Health and Substance Abuse Program	$20 Copayment – Visit to Outpatient Substance Abuse Treatment Program $20 Copayment – Visit to Mental Health Professional $70 Copayment – Emergency Department Visit
Prescription Drug Program	Up to a 90-day supply from a Network Pharmacy, Mail Service Pharmacy or the Specialty Pharmacy (see copayment chart on page 15).