Health Insurance
Choices for 2010

October 2009

For Employees of the State of New York who are unrepresented or in Negotiating Units that have agreements/awards with New York State beginning April 1, 2007, Employees of Participating Employers and for COBRA enrollees with their NYSHIP benefits (Check with your agency Health Benefits Administrator or union if you are uncertain.)

NYSHIP
New York State Health Insurance Program

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During the Option Transfer Period, you may make two important choices for 2010

Choose Your Health Insurance Plan

This booklet explains the options available to you under the New York State Health Insurance Program (NYSHIP). Choose either The Empire Plan or one of the NYSHIP-approved Health Maintenance Organizations (HMOs) in your area. Consider your health insurance options carefully. You may not change your health insurance option after the deadline except in special circumstances. (See your *NYSHIP General Information Book* and *Empire Plan Reports* or *HMO Reports* for details about changing options outside the Option Transfer Period.) If you still have specific questions after you've read the plan descriptions, contact The Empire Plan carriers and HMOs directly.

Rates for 2010 and Deadline for Changing Plans

The Empire Plan and HMO rates for 2010 are mailed to your home and posted on our web site as soon as they are approved. *(Participating Employers, such as the Thruway Authority and MTA, will notify their enrollees of 2010 rates.)* The rate flyer announces the option change deadline and paycheck deduction dates. You have 30 days from the date your agency receives rate information to make a decision. Rates are posted on the New York State Department of Civil Service web site at https://www.cs.state.ny.us as soon as they are approved. Click on Benefit Programs, then on NYSHIP Online. Select your group if prompted, and then click on Health Benefits & Option Transfer. Choose Rates and Health Plan Choices. Your agency Health Benefits Administrator (HBA) can help if you have questions. COBRA enrollees may contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico and the Virgin Islands).

See your agency Health Benefits Administrator to change your health insurance option, enrollment or pre-tax status.

NO ACTION IS REQUIRED IF YOU DO NOT WISH TO MAKE CHANGES.

Changes are not automatic and deadlines apply. You must report any change that may affect your coverage to your agency Health Benefits Administrator. See pages 1-3 in this booklet and your *NYSHIP General Information Book* for complete information.

Choose Your Pre-Tax Contribution Program Status by November 30, 2009

The following does NOT apply to employees of Participating Employers. Ask your agency Health Benefits Administrator (HBA) if a Pre-Tax Contribution Program (PTCP) is available to you. Pre-tax does not apply to COBRA enrollees.

Under the Pre-Tax Contribution Program, your health insurance premiums are deducted from your pay before taxes are taken out. This lowers your taxable income and increases your spendable income. Only the portion of the premium that pays for Individual coverage may be deducted on a pre-tax basis for employees who provide health benefits for non-federally qualified domestic partners. Your paycheck stub shows whether or not you are enrolled in PTCP.

- **Regular Before Tax Health** appears in the Before Tax Deductions section if your health insurance premium is deducted from your wages before taxes are withheld.
- **Regular After Tax Health** appears in the After Tax Deductions section if your health insurance premium is deducted from your wages after taxes are withheld.
- **Regular Before Tax Health** appears in the Before Tax Deductions section AND **Regular After Tax Health** appears in the After Tax Deductions section if you have elected pre-tax and have a non-federally qualified domestic partner or same sex spouse. Under federal law, the premium for such dependents cannot be deducted before taxes are withheld.

Under PTCP, you can make the following changes only in November each year:

- Change from Family to Individual coverage while your dependents are still eligible for coverage,
- Voluntarily cancel your coverage while you are still eligible for coverage, or
- Opt out of PTCP.

Under Internal Revenue Service (IRS) rules, you may change your health insurance deduction during the tax year only after a PTCP-qualifying event. For a list of PTCP-qualifying events, see your *NYSHIP General Information Book*. To change your pre-tax selection for 2010, see your agency HBA and complete a health insurance transaction form (PS-404) by November 30, 2009.

Your Biweekly Premium Contribution

The following does NOT apply to employees of Participating Employers. Participating Employers will provide premium information. It also does not apply to COBRA enrollees.

New York State helps pay for your health insurance coverage. After the State's contribution, you are responsible for paying the balance of your premium through biweekly deductions from your paycheck.

- For Empire Plan enrollees, the State pays 90 percent of the cost of the premium for enrollee coverage and 75 percent of the premium for dependent coverage.
- For HMO enrollees, the State pays 90 percent of the premium for enrollee coverage and 75 percent for dependent coverage. However, the State's dollar contribution for the non-prescription drug components of the HMO premium will NOT exceed its dollar contribution for the non-prescription drug components of The Empire Plan premium.

As soon as they are available, 2010 rates will be mailed to your home and posted on our web site at https://www.cs.state.ny.us. Click on Benefit Programs, then on NYSHIP Online. Select your group if prompted, and then click on Health Benefits & Option Transfer. Choose Rates and Health Plan Choices.

Information and Reminders

Let Your Agency Know about Changes

You must notify your agency HBA if your home address or phone number changes. If you are an active or retired employee of New York State or are retired from a Participating Employer and registered for MyNYSHIP, you may also make address and option changes online.

Changes in your family status, such as gaining or losing a dependent, may mean you need to change your health insurance coverage from Individual to Family or from Family to Individual. If you submit a timely request, you can make most changes any time, not just during the Option Transfer Period. See your *NYSHIP General Information Book* for details. Inform your agency HBA about any change promptly to ensure it is effective on the actual date of change in family status.

Retiring or Vesting in 2010?

You may change your health insurance plan when you retire or vest your health insurance. Retirees and vestees who continue their NYSHIP enrollment may change health insurance options at any time once during a 12-month period. For more information on changing options as a retiree, ask your agency HBA for *Choices for 2010* for Retirees.

Eligible for Medicare?

If you or a dependent is eligible for Medicare because of age or disability, see "Medicare and NYSHIP" on page 4 for important information. Also, please read this section if you or a dependent will be turning age 65 in 2010 or if you are planning to retire in the coming year and will be Medicare-eligible.

Choosing Your Health Plan

Choosing the health insurance plan to cover your needs and the needs of your family requires careful research. As with most important purchases, there is more to consider than cost. Selecting a health plan is an important and personal decision. Only you know your family lifestyle, health, budget and benefit preferences. Think carefully about what you need from your health plan so you are better prepared to make a choice.

The first step in making a good choice is understanding the similarities and the differences between your NYSHIP options. There are two types of health insurance plans available to you under NYSHIP: The Empire Plan and NYSHIP Health Maintenance Organizations (HMOs). The Empire Plan is available to all employees. Specific NYSHIP HMOs are available in the various geographic areas of New York State. Depending on where you live or work, one or several NYSHIP HMOs will be available to you. The Empire Plan and NYSHIP HMOs are similar in many ways, but also have important differences.

Benefits

The Empire Plan and NYSHIP HMOs

- All NYSHIP plans provide a wide range of hospital, medical/surgical, and mental health and substance abuse coverage.
- All plans provide prescription drug coverage if you do not receive it through a union Employee Benefit Fund.

Benefits differ among plans. Read this booklet and the certificate/contracts carefully for details.

Exclusions

- All plans contain exclusions for certain services and prescription drugs.
- Workers' compensation-related expenses and custodial care generally are excluded.

For details on a plan's exclusions, read the *NYSHIP General Information Book* and *Empire Plan Certificate,* the HMO contract, or check with the plan directly.

Geographic Area Served

The Empire Plan

Benefits for all covered services – not just urgent and emergency care – are available worldwide.

Health Maintenance Organizations (HMOs)

- Coverage is available in the HMO's specific service area.
- An HMO may arrange care outside its service area, at its discretion in certain circumstances.

Benefits Provided by The Empire Plan and All NYSHIP HMOs

Please see the individual plan descriptions in this booklet to review the differences in coverage and out-of-pocket expenses. See plan documents for complete information on benefits.

- Inpatient medical/surgical hospital care
- Outpatient medical/surgical hospital services
- Physician services
- Emergency services
- Laboratory services
- Radiology services
- Diagnostic services
- Diabetic supplies
- Maternity, prenatal care
- Well child care
- Chiropractic services
- Physical therapy
- Occupational therapy
- Speech therapy
- Prosthetics and durable medical equipment
- Orthotic devices
- Bone density tests
- Mammography
- Inpatient mental health services
- Outpatient mental health services
- Alcohol and substance abuse detoxification
- Inpatient alcohol rehabilitation
- Inpatient drug rehabilitation
- Outpatient alcohol and drug rehabilitation
- Family planning and certain infertility services (Call The Empire Plan carriers or HMO for details.)
- Out-of-area emergencies
- Hospice benefits (at least 210 days)
- Home health care in lieu of hospitalization
- Prescription drug coverage including injectable medications, self-injectable medications, contraceptive drugs and devices and fertility drugs (unless you have coverage through a union Employee Benefit Fund)
- Enteral formulas covered through either HCAP for The Empire Plan or the HMO's prescription drug program (unless you have coverage through a union Employee Benefit Fund)
- Second opinion for cancer diagnosis

Medicare and NYSHIP

If you are an active employee, NYSHIP (The Empire Plan or a NYSHIP HMO) provides primary coverage for you and your dependents, regardless of age or disability.

Exceptions: Medicare is primary for your domestic partner age 65 or over, or for an active employee or dependent with end-stage renal disease (waiting period applies).

NYSHIP requires you and your dependents to be enrolled in Medicare Parts A and B when first eligible for Medicare coverage that pays primary to NYSHIP.

If you are planning to retire, and you or your spouse is 65 or older, contact your Social Security office three months before active employment ends to enroll in Medicare Parts A and B. Medicare becomes primary to your NYSHIP coverage the first day of the month following a "runout" period of 28 days after the payroll period in which you retire.

If you or a dependent is eligible for Medicare coverage primary to NYSHIP but fails to enroll in Parts A and B, The Empire Plan or HMO will not provide benefits for services Medicare would have paid if you or your dependent had enrolled.

If you are planning to retire or vest in 2010, know how your NYSHIP benefits will be affected when Medicare is your primary coverage:

- **If you are enrolled in original Medicare (Parts A and B) and have secondary coverage under The Empire Plan:** The Empire Plan coordinates benefits with Medicare. Since Medicare does not provide coverage outside the United States, The Empire Plan pays primary for covered services received outside the United States.
- **If you enroll in a NYSHIP HMO Medicare Advantage Plan:** You replace your original fee-for-service Medicare coverage with benefits offered by the Medicare Advantage Plan. Benefits under the HMO's Medicare Advantage Plan may differ from your benefits as an active employee. To qualify for benefits, you must follow plan rules (except for emergency or out-of-area urgently needed care).
- **If you enroll in a NYSHIP HMO that coordinates coverage with Medicare:** You receive the same benefits from the HMO as an active employee and still qualify for original Medicare benefits if you receive treatment outside your HMO.
- **If you are enrolled in The Empire Plan and join a Medicare Advantage Plan that is not part of NYSHIP:** If you receive services that are not authorized by your Medicare Advantage Plan, The Empire Plan will not pay for Medicare-covered services that would have been covered by the Medicare Advantage Plan.

Medicare Part D is the Medicare prescription drug benefit for Medicare-eligible persons. NYSHIP provides prescription drug benefits to you and your dependents under The Empire Plan or a NYSHIP HMO. Enrolling in a Medicare Part D plan separate from your NYSHIP coverage may drastically reduce your benefits overall. For example:

- If you are Medicare-primary and enrolled in both The Empire Plan and a Medicare Part D plan, you will not be able to use your Empire Plan coverage to receive benefits at the pharmacy. You must use your Medicare drug coverage first. To receive secondary drug coverage, you must submit a claim to The Empire Plan Prescription Drug Program along with documentation of the amount covered by Medicare.
- If you are enrolled in a NYSHIP Medicare Advantage HMO and then enroll in a Medicare Part D plan or another Medicare Advantage Plan outside of NYSHIP, Medicare will terminate your enrollment in the NYSHIP HMO.

If you are eligible for the extra help from the Medicare Part D Low Income Subsidy, or if you are interested in additional drug coverage offered by a Medicare Part D plan, be sure you understand how joining a Medicare prescription drug plan will change your NYSHIP coverage **before** enrolling. If you do enroll in Medicare Part D, you will not be reimbursed for the Medicare Part D premium.

If you receive prescription drug coverage through a union Employee Benefit Fund, contact the fund for information about Medicare Part D.

For more information about NYSHIP and Medicare, see your *NYSHIP General Information Book* or ask your agency HBA for a copy of *Choices for 2010* for Retirees, *Planning for Retirement, Medicare & NYSHIP* or *Medicare for Disability Retirees.*

The Empire Plan or a NYSHIP HMO

What's New in 2010?

All NYSHIP Plans

- Effective July 1, 2009, continuation coverage has been extended from 18 to 36 months for all COBRA enrollees.
- Effective January 1, 2010, unmarried children of NYSHIP enrollees who are under age 30 and not eligible for health insurance through their own employer may enroll in the same NYSHIP option as their parents if they live or work in the NYSHIP plan's service area. These young adult dependents will pay the full cost of Individual coverage. NYSHIP enrollees will receive detailed information regarding eligibility, cost and enrollment for young adult children through age 29 in October 2009.
- On January 1, 2010, the federal parity law for substance abuse benefits takes effect. The law requires that benefit levels for substance abuse care must be the same as those for hospital/medical benefits.

NYSHIP HMOs
Effective January 1, 2010

- Univera Healthcare will no longer be offered under NYSHIP. If you are enrolled in Univera Healthcare, you must enroll in The Empire Plan or a NYSHIP-approved HMO in the area where you live or work. If you do not take action, you will automatically be enrolled in The Empire Plan for the 2010 program year.
- Oneida County returns to CDPHP's Medicare Advantage Plan (NYSHIP code number 300).
- MVP Central Region (NYSHIP code number 330) expands into Tompkins County.
- Preferred Care changed its name to MVP Health Care as of April 30, 2009.

The Empire Plan

The Empire Plan is a unique plan designed exclusively for New York State's public employees. The Empire Plan has many managed care features, but enrollees are not required to choose a primary care physician and do not need referrals to see specialists. However, certain services, such as hospital and skilled nursing facility admissions, certain outpatient radiological tests, mental health and substance abuse treatment, home care and some prescription drugs, require preapproval. Coverage is available worldwide. It is not limited to your geographic area. The New York State Department of Civil Service contracts with major insurance companies (carriers) to insure and administer different parts of the Plan.

The Empire Plan provides:

- Network and non-network inpatient and outpatient hospital coverage for medical, surgical and maternity care;
- Medical and surgical coverage. Coverage under the Participating Provider Program or the Basic Medical Program and Basic Medical Provider Discount Program if you choose a non-participating provider;
- Home care services, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes through the Home Care Advocacy Program (HCAP);
- Physical medicine (chiropractic treatment and physical therapy) coverage;
- Inpatient and outpatient mental health and substance abuse coverage;
- Prescription drug coverage;
- Centers of Excellence Programs for cancer, transplants and infertility;

- 24-hour Empire Plan NurseLine℠ for health information and support; and
- Worldwide coverage.

Cost Sharing

Under The Empire Plan, benefits are available for covered services when you use a participating or non-participating provider. However, your share of the cost of covered services depends on whether the provider you use is participating or non-participating under the Plan.

If you use an Empire Plan participating or network provider for medical, surgical, mental health or substance abuse services, you pay a copayment for certain services; some are covered at no cost to you. The provider files the claim and is reimbursed by The Empire Plan.

You are guaranteed access to network benefits for certain services when you contact the program before receiving services and follow program requirements:

- Inpatient hospital stays;
- Mental Health and Substance Abuse Program services;
- Managed Physical Medicine Program services (physical therapy and chiropractic care); and
- Home Care Advocacy Program (HCAP) services (home care and services, including durable medical equipment).

If you use a non-participating provider for medical and surgical services, benefits for covered services are paid under the Basic Medical Program. After you satisfy an annual deductible:

- The Empire Plan pays 80 percent of the reasonable and customary charge.
- You are responsible for the 20 percent coinsurance and charges in excess of the reasonable and customary charge.
- After you reach the out-of-pocket maximum, you will be reimbursed up to 100 percent of the reasonable and customary charge. See the chart on page 8 for the Basic Medical deductible and coinsurance maximum amounts that apply to you, based on your employee group.
- You are responsible for paying the provider and will be reimbursed by the Plan for covered charges.

Consider Cost

Although New York State pays most of the premium cost for your coverage regardless of which plan you choose, differences in plan benefits among the various health insurance options result in different employee contributions for coverage. (See Your Biweekly Premium Contribution on page 1.) However, when considering cost, think about all your costs throughout the year, not just your biweekly paycheck deduction. Keep in mind out-of-pocket expenses you are likely to incur during the year, such as copayments for prescriptions and other services, coinsurance and any costs of using providers or services not covered under the plan. Add the annual premium for that plan to these costs to estimate your total annual cost under that plan. Do this for each plan you are considering and compare the costs. Watch for the *NYSHIP Rates & Deadlines for 2010* flyer that will be mailed to your home and posted on our web site, https://www.cs.state.ny.us, as soon as rates are approved. Along with this booklet, which provides copayment information, *NYSHIP Rates & Deadlines for 2010* will provide the information you need to figure your annual cost under each of the available plans.

Basic Medical Provider Discount Program

If you are Empire Plan-primary, The Empire Plan also includes a program to reduce your out-of-pocket costs when you use a non-participating provider. This program, The Empire Plan Basic Medical Provider Discount Program, offers discounts from certain physicians and providers who are not part of The Empire Plan participating provider network. These providers are part of the nationwide MultiPlan group, a provider organization contracted with UnitedHealthcare. Empire Plan Basic Medical Provider Discount Program provisions apply and you must meet the annual deductible.

Providers in the Basic Medical Provider Discount Program accept a discounted fee for covered services. Your 20 percent coinsurance is based on the lower of

the discounted fee or the reasonable and customary charge. The provider submits your claims and UnitedHealthcare pays The Empire Plan portion of the provider fee directly to the provider if the services qualify for the Basic Medical Provider Discount Program. Your Explanation of Benefits, which details claims payments, shows the discounted amount applied to billed charges.

To find a provider in The Empire Plan Basic Medical Provider Discount Program, ask if the provider is an Empire Plan MultiPlan provider or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447), choose The Empire Plan Medical Benefits Program and ask a representative for help. You can also visit the New York State Department of Civil Service web site at https://www.cs.state.ny.us. Click on Benefit Programs, then on NYSHIP Online. Select the group if prompted, and then click on Find a Provider.

The best savings are with participating providers. If you choose a non-participating or non-network provider for services covered under the Mental Health and Substance Abuse Program, the Managed Physical Medicine Program or the Home Care Advocacy Program, benefits for non-network coverage are lower and subject to separate deductibles and coinsurance. Under the Managed Physical Medicine Program, non-network coverage is also subject to benefit limits. For more information on coverage provided under The Empire Plan, see the publication, *Reporting on Network Benefits.* You can find this publication on our web site at https://www.cs.state.ny.us. Or, ask your agency HBA for a copy.

Providers

Under The Empire Plan you can choose from over 275,000 participating physicians and other providers nationwide, and from more than 50,000 participating pharmacies across the United States or a mail service pharmacy.

Medically necessary visits to specialists are covered without referral or prior authorization. Basic Medical or non-network benefits are available for covered services received from non-participating providers, depending on the type of service.

NYSHIP Health Maintenance Organizations

A Health Maintenance Organization (HMO) is a managed care system in a specific geographic area that provides comprehensive health care coverage through a network of providers.

- Coverage outside the specified geographic area is limited.
- Enrollees usually choose a primary care physician (PCP) from the HMO's network for routine medical care and for referrals to specialists and hospitals when medically necessary.
- HMO enrollees usually pay a copayment as a per-visit fee or coinsurance (percentage of cost).
- HMOs have no annual deductible.
- Referral forms to see network specialists usually are required.
- Claim forms rarely are required.
- HMO enrollees who use doctors, hospitals or pharmacies outside the HMO's network must, in most cases, pay the full cost of services (unless authorized by the HMO or in an emergency).

All NYSHIP HMOs provide a wide range of health services. Each offers a specific package of hospital medical, surgical and preventive care benefits. These services are provided or arranged by the primary care physician selected by the enrollee from the HMO's staff or physician network.

All NYSHIP HMOs cover inpatient and outpatient hospital care at a network hospital and offer prescription drug coverage unless it is provided through a union Employee Benefit Fund.

NYSHIP HMOs are organized in one of two ways:

- A Network HMO provides medical services that can include its own health centers as well as outside participating physicians, medical groups and multi-specialty medical centers.
- An Independent Practice Association (IPA) HMO provides medical services through private practice physicians who have contracted independently with the HMO to provide services in their offices.

Members enrolling in Network and IPA model HMOs may be able to select a doctor they already know if that doctor participates with the HMO.

See the individual HMO pages in this booklet for additional benefit information and to learn if the HMO serves your geographic area.

Empire Plan Basic Medical Program and Non-Network Mental Health/Substance Abuse Practitioner Services Effective January 1, 2010

Employee Group	**Annual Deductible**[1] (per enrollee; per spouse or domestic partner; per all dependent children combined)	**Coinsurance Maximum**[1] (Out-of-Pocket Expense per contract for Council 82, ALESU and NYSCOPBA (Contract Affected) **or** per enrollee; per spouse or domestic partner; per all dependent children combined for all other groups listed below)
Executive Branch		
CSEA	$250	$500/$300[3]
DC-37	$290 CPI[2]	$620 CPI[2]/$300[3]
PBA - Troopers	$375 CPI[2]	$826 CPI[2]
PBA - Supervisors	$375 CPI[2]	$826 CPI[2]
PIA	$375 CPI[2]	$826 CPI[2]
Council 82	$375 CPI[2]	$1,389 CPI[2]
ALESU	$375 CPI[2]	$1,389 CPI[2]
NYSCOPBA (Contract Affected)	$375 CPI[2]	$1,389 CPI[2]
NYSCOPBA (Represented)	$375 CPI[2]	$800
UUP	$375 CPI[2]	$1,033 CPI[2]
PEF	$375 CPI[2]	$1,033 CPI[2]
M/C	$375 CPI[2]	$1,033 CPI[2]
Legislature	$375 CPI[2]	$1,033 CPI[2]
Participating Employers	$375 CPI[2]	$1,033 CPI[2]
Unified Court System	$250	$500/$300[3]
Retirees, Vestees, Dependent Survivors and Preferred List	$375 CPI[2]	$1,033 CPI[2]

1 Each program's deductible, coinsurance and maximum coinsurance amount for medical, MPN, mental health and substance abuse services is separate and not combined with any other deductible, coinsurance or maximum coinsurance amount.
2 These changes reflect the 3.3% increase in the medical care component of the Consumer Price Index for Urban Wage Earners and Clerical Workers, all Cities (C.P.I.-W.) for the period July 1, 2008 through June 30, 2009.
3 The coinsurance maximum out-of-pocket expense will be reduced to $300 for calendar year 2010 for employees in (or equated to) salary grade 6 or below on January 1, 2010. This reduction is not available to Judges and Justices.

Note: You have no deductible or coinsurance when you use Empire Plan participating providers.

The Empire Plan and NYSHIP HMOs: Similarities and Differences

The Empire Plan	NYSHIP HMOs
Can I use the hospital of my choice?	
Yes. You have coverage worldwide, but your benefits differ depending on whether you choose a network or non-network hospital[1]. Your benefits are highest at network hospitals participating in the BlueCross and BlueShield Association BlueCard® PPO Program, or for mental health or substance abuse care in the OptumHealth network. Network hospital inpatient: Paid-in-full hospitalization benefits. Network hospital outpatient and emergency care: Subject to network copayments. Non-network hospital inpatient and outpatient: 10 percent coinsurance[2] up to an annual maximum of $1,500 per enrollee; per spouse or domestic partner; per all dependent children combined. Note: $500 of $1,500 coinsurance maximum is reimbursable under the Basic Medical Program.	Except in an emergency, you generally do not have coverage at non-participating hospitals unless authorized by the HMO.
If I am diagnosed with a serious illness, can I see a physician or go to a hospital that specializes in my illness?	
Yes. You can use the specialist of your choice. You have Basic Medical Program benefits for non-participating providers and Basic Medical Provider Discount Program benefits for non-participating providers who are part of The Empire Plan MultiPlan group[1]. (See pages 6 and 7 for more information on the Basic Medical Provider Discount Program.) Your hospital benefits will differ depending on whether you choose a network or non-network hospital[1]. (See above for details.)	You should expect to choose a participating physician and a participating hospital. Under certain circumstances, you may be able to receive a referral to a specialist care center outside the network.
Can I be sure I will not need to pay more than my copayment when I receive medical services?	
Yes. Your copayment should be your only expense if you: • Choose a participating provider; • Receive inpatient or covered outpatient hospital services at a network hospital and follow Benefits Management Program requirements[1].	Yes. As long as you follow HMO requirements and receive the appropriate referral, your copayment (or coinsurance) should be your only expense.

The Empire Plan	NYSHIP HMOs
Will I be covered for care I receive away from home?	
Yes. Under The Empire Plan, your benefits are the same wherever you receive care.	Under an HMO, you are covered away from home only for emergency care. Some HMOs provide coverage for routine care if the HMO has reciprocity with another HMO. Some HMOs provide coverage for college students away from home if the care is urgent or if follow-up care has been preauthorized. See the Out of Area Benefit description on each HMO page for more information.
What kind of care is available for physical therapy and chiropractic care?	
You have guaranteed access to unlimited medically necessary care when you choose participating providers and follow Plan requirements.	Coverage is available for a specified number of days/visits each year, as long as you follow the HMO's requirements.
What if I need durable medical equipment, medical supplies or home nursing?	
You have guaranteed, paid-in-full access to medically necessary home care, equipment and supplies[3] through the Home Care Advocacy Program (HCAP) when preauthorized and arranged by the Plan.	Benefits are available and vary depending on the HMO. Benefits may require a greater percentage of cost-sharing.

[1] Applies only to Empire Plan-primary enrollees
[2] Greater of 10 percent coinsurance or $75 for outpatient
[3] Diabetic shoes have an annual maximum benefit of $500.

Note: These responses are generic and highlight only general differences between The Empire Plan and NYSHIP HMOs. Details for each plan are available on individual plan pages beginning on page 16 of this booklet, in the *Empire Plan Certificate* (available from your agency Health Benefits Administrator) and in the HMO contract (available from each HMO).

Questions and Answers

Q: Can I join The Empire Plan or any NYSHIP-approved HMO?

A: The Empire Plan is available worldwide, wherever you live or work. To enroll or continue enrollment in a NYSHIP-approved HMO, you must live or work in that HMO's service area. If you move permanently out of and/or no longer work in your HMO's service area, you must change options. See Plans by County on pages 14 and 15 and the individual HMO pages in this booklet to check the counties each HMO will serve in 2010.

Q: How do I find out which providers and hospitals participate? What if my doctor or other provider leaves my plan?

A: Check with your providers directly to see whether they participate in The Empire Plan for New York State government employees or in a NYSHIP HMO.

For Empire Plan providers:

- Visit https://www.cs.state.ny.us; click on Benefit Programs, then on NYSHIP Online. Select your group if prompted, and then click on Find a Provider.
- Ask your agency Health Benefits Administrator for *The Empire Plan Participating Provider Directory.*
- Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program for the type of provider you need.

For HMO providers:

- Visit the web sites (web site addresses are provided on the individual HMO pages in this booklet) for provider information.
- Call the telephone numbers on the HMO pages in this booklet. Ask which providers participate and which hospitals are affiliated.

If you choose a provider who does not participate in your plan, check carefully whether benefits would be available to you. Ask if you need authorization to have the provider's services covered. In most circumstances, HMOs do not provide benefits for services by non-participating providers or hospitals. Under The Empire Plan, you have benefits for participating and non-participating providers.

Participating providers change. You cannot change your plan outside the Option Transfer Period because your provider no longer participates.

Q: I have a preexisting condition. Will I have coverage if I change options?

A: Yes. Under NYSHIP, you can change your option and still have coverage for a preexisting condition. There are no preexisting condition exclusions in any NYSHIP plan. However, coverage and exclusions differ. Ask the plan you are considering about coverage for your condition.

Q: What if I retire in 2010 and become eligible for Medicare?

A: Regardless of which option you choose, as a retiree, you and your dependent must be enrolled in Medicare Parts A and B when either of you first becomes eligible for primary Medicare coverage. Please read about Medicare and NYSHIP and Medicare Part D on page 4.

Please note, especially, that your NYSHIP benefits become secondary to Medicare and that your benefits may change when you enroll in some HMOs.

Q: I am a COBRA dependent in a Family plan. Can I switch to Individual coverage and select a different health plan from the rest of my family?

A: Yes. As a COBRA dependent, you may elect to change to Individual coverage in a plan different from the enrollee's Family coverage. During the Option Transfer Period, you may enroll in The Empire Plan or choose any NYSHIP-approved HMO in the area where you live or work.

Terms to Know

- **Coinsurance:** The enrollee's share of the cost of covered services; a fixed percentage of medical expenses.
- **Copayment:** The enrollee's share of the cost of covered services that is a fixed dollar amount paid when medical service is received, regardless of the total charge for service.
- **Deductible:** The dollar amount an enrollee is required to pay before health plan benefits begin to reimburse for services.
- **Fee-for-service:** A method of billing for health care services. A provider charges a fee each time an enrollee receives a service.
- **Formulary:** A list of preferred drugs used by a health plan. If a plan has a **closed formulary**, you have coverage only for drugs that appear on the list. An **incented formulary** encourages use of preferred drugs to non-preferred drugs based on a tiered copayment schedule. In a **flexible formulary**, brand-name prescription drugs may be assigned to different copayment levels based on value to the plan and clinical judgment. In some cases, drugs may be excluded from coverage under a flexible formulary if a therapeutic equivalent is covered or available as an over-the-counter drug.
- **Health Benefits Administrator (HBA):** Personnel located in each State agency, often in the Human Resources or Personnel Office, who work with the Employee Benefits Division in the Department of Civil Service to process enrollment transactions and answer health insurance questions. You are responsible for notifying your agency HBA of changes that might affect your enrollment.
- **Health Maintenance Organization (HMO):** A managed care delivery system organized to deliver health care services in a geographic area. An HMO provides a predetermined set of benefits through a network of selected physicians, laboratories and hospitals for a prepaid premium. Except for emergency services, you and your enrolled dependents may have coverage only for services received from your HMO's network. See NYSHIP Health Maintenance Organizations on page 7 for more information on HMOs including descriptions of the two different types, Network and Independent Practice Association (IPA), that are offered under NYSHIP.
- **Managed Care:** A health care program designed to ensure you receive the highest quality medical care for the lowest cost, in the most appropriate health care setting. Most managed care plans require you to select a primary care physician employed by (or who contracts with) the managed health care system. He/she serves as your health care manager by coordinating virtually all health care services you receive. Your primary care physician provides your routine medical care and refers you to a specialist if necessary.
- **Medicare:** A federal health insurance program that covers certain people age 65 or older, disabled persons under 65, and those who have end-stage renal disease (permanent kidney failure). Medicare is directed by the federal Centers for Medicare & Medicaid Services (CMS) and administered by the Social Security Administration.
- **Medicare Advantage Plan:** Medicare option wherein the HMO agrees with Medicare to accept a fixed monthly payment for each Medicare enrollee. In exchange, the HMO provides or pays for all medical care needed by the enrollee. If you join a Medicare Advantage Plan, you replace your original Medicare coverage (Parts A and B) with benefits offered by the HMO and all of your medical care (except for emergency or out-of-area urgently needed care) must be provided, arranged or authorized by the Medicare Advantage Plan. Most Medicare Advantage Plans include Medicare Part D drug coverage. The benefits under these HMOs are set in accordance with Medicare's guidelines for Medicare Advantage Plans.
- **Network:** A group of doctors, hospitals and/or other health care providers who participate in a health plan and agree to follow the plan's procedures.
- **New York State Health Insurance Program (NYSHIP):** NYSHIP covers over 1.2 million public employees, retirees and dependents and is one of the largest group health insurance programs in the country. The Program provides health care benefits through The Empire Plan or a NYSHIP-approved HMO.
- **Option:** A health insurance plan offered through NYSHIP. Options include The Empire Plan and NYSHIP-approved HMOs within specific geographic areas.

Making a Choice

Decision-Making Checklist

Choosing a health insurance plan is an important decision. Think about what health care you and your family might need during the next year. Review the plans and ask for more information. Here are several questions to consider:

- What benefits does the plan have for doctor visits and other medical care? How are durable medical equipment and other supplies covered? What is my share of the cost?
- What benefits does the plan have for prescription drugs? Will the medicine I take be covered under the plan? *(Employees of Participating Employers: If you receive your drug coverage from a union Employee Benefit Fund, that coverage will not be affected by a change in your health insurance plan.)* What is my share of the cost? What type of formulary does the plan have? Am I required to use the mail service pharmacy?
- What choice of providers do I have under the plan? (Ask if the provider or facilities you use are covered.) How would I consult a specialist if I needed one? Would I need a referral?
- What is my premium for the health plan?
- What will my out-of-pocket expenses for health care be?
- Does the plan cover special needs? Are there any benefit limitations? (If you or one of your dependents has a medical or mental health/substance abuse condition requiring specific treatment or other special needs, check on coverage carefully. Don't assume you'll have coverage. Ask The Empire Plan carriers or HMOs about your specific treatment.)
- Are routine office visits and urgent care covered for out-of-area college students, or is only emergency health care covered?
- How much paperwork is involved in the health plan – do I have to fill out forms?

To generate an easy-to-read side-by-side comparison of the benefits provided by each of the NYSHIP plans in your area, use the NYSHIP Plan Comparison tool, available on the Department of Civil Service web site. Go to our home page at https://www.cs.state.ny.us, click on Benefit Programs then NYSHIP Online. Select your group if prompted and then choose Health Benefits & Option Transfer. Click on Rates and Health Plan Choices and then NYSHIP Plan Comparison. Select your group and the counties in which you live and work. Then, check the box next to the plans you want to compare and click on Compare Plans to generate the comparison table.

Things to Remember

- Gather as much information as possible.
- Consider the unique needs of yourself and your family.
- Compare the coverage and cost of your options.
- Look for a health plan that provides the best balance of cost and benefits for you.

What You Need to Do

The Empire Plan and NYSHIP HMOs are summarized in this booklet. The Empire Plan is available to all employees. NYSHIP HMOs are available to employees in areas where they live or work. Pick the plans that would serve your needs best and call each for details before you choose.

If you decide to change your benefit plan:

- See your agency Health Benefits Administrator before the Option Transfer deadline announced in the rate flyer.
- Complete the necessary PS-404 form. Or change your option online using MyNYSHIP if you are an active employee of a New York State agency.

How to Use the *Choices* Benefit Charts, Pages 16 – 43

All NYSHIP plans must include a minimum level of benefits (see page 3). For example, The Empire Plan and all NYSHIP HMOs provide a paid-in-full benefit for medically necessary inpatient medical/surgical hospital care at network hospitals.

Use the charts to compare the plans. The charts list out-of-pocket expenses and benefit limitations effective on or about January 1, 2010. See plan documents for complete information on benefit limitations.

A Reminder

Most benefits described in this booklet are subject to medical necessity and may involve limitations or exclusions. Please refer to plan documents, or call the plans directly for details.

Plans by County

The Empire Plan

The Empire Plan is available to all enrollees in the New York State Health Insurance Program (NYSHIP). You may choose The Empire Plan regardless of where you live or work. Coverage is worldwide. See pages 16-21 for a summary of The Empire Plan.

Health Maintenance Organizations (HMOs)

Most NYSHIP enrollees have a choice among HMOs. You may enroll, or continue to be enrolled, in any NYSHIP-approved HMO that serves the area where you live or work. You may not be enrolled in an HMO outside your area. This list will help you determine which HMOs are available by county. The pages indicated will describe benefits available from each HMO.

Page in Choices	16	22	24	26	26	26	28	30	30	30	32	32	34	36	36	38	40	40	40	40	42
	The Empire Plan	Aetna*	Blue Choice*	CDPHP*	CDPHP*	CDPHP*	Community Blue*	Empire BlueCross BlueShield HMO	Empire BlueCross BlueShield HMO	Empire BlueCross BlueShield HMO	GHI HMO	GHI HMO	HIP*	HMOBlue	HMOBlue	Independent Health*	MVP*	MVP*	MVP	MVP	MVP*
NYSHIP CODE	001	210	066	063	300	310	067	280	290	320	220	350	050	072	160	059	060	330	340	360	058
Albany	•			•				•			•						•				
Allegany	•						•									•					
Bronx	•	•							•				•								
Broome	•				•									•				•			
Cattaraugus	•						•									•					
Cayuga	•													•				•			
Chautauqua	•						•									•					
Chemung	•													•							
Chenango	•				•										•			•			
Clinton	•							•							•						
Columbia	•			•				•			•						•				
Cortland	•													•				•			
Delaware	•				•			•			•				•			•			
Dutchess	•					•				•		•							•		
Erie	•						•									•					
Essex	•				•			•							•						
Franklin	•														•					•	
Fulton	•			•				•							•		•				
Genesee	•						•									•					•
Greene	•			•				•			•						•				
Hamilton	•				•												•				
Herkimer	•				•										•			•			
Jefferson	•														•			•			
Kings	•	•							•				•								
Lewis	•														•			•			
Livingston	•		•																		•
Madison	•				•										•			•			

*Medicare-primary NYSHIP enrollees will be enrolled in this HMO's Medicare Advantage Plan. For more information about NYSHIP Medicare Advantage Plans, ask your agency Health Benefits Administrator for a copy of *Choices for 2010* for Retirees.

Page in Choices	16	22	24	26	26	26	28	30	30	30	32	32	34	36	36	38	40	40	40	40	42
	The Empire Plan	Aetna*	Blue Choice*	CDPHP*	CDPHP*	CDPHP*	Community Blue*	Empire BlueCross BlueShield HMO	Empire BlueCross BlueShield HMO	Empire BlueCross BlueShield HMO	GHI HMO	GHI HMO	HIP*	HMOBlue	HMOBlue	Independent Health*	MVP*	MVP*	MVP	MVP	MVP*
NYSHIP CODE	001	210	066	063	300	310	067	280	290	320	220	350	050	072	160	059	060	330	340	360	058
Monroe	•		•																		•
Montgomery	•			•				•							•		•				
Nassau	•	•							•				•								
New York	•	•							•				•								
Niagara	•						•									•					
Oneida	•				•										•			•			
Onondaga	•													•				•			
Ontario	•		•																		•
Orange	•	•				•				•		•							•		
Orleans	•						•									•					•
Oswego	•													•				•			
Otsego	•				•										•			•			
Putnam	•	•								•		•							•		
Queens	•	•							•				•								
Rensselaer	•			•				•			•						•				
Richmond	•	•							•				•								
Rockland	•	•							•			•							•		
Saratoga	•			•				•			•						•				
Schenectady	•			•				•			•						•				
Schoharie	•			•				•									•				
Schuyler	•													•							
Seneca	•		•																		•
St. Lawrence	•														•					•	
Steuben	•													•							•
Suffolk	•	•							•				•								
Sullivan	•	•								•		•							•		
Tioga	•				•									•				•			
Tompkins	•													•				•			
Ulster	•					•				•		•							•		
Warren	•			•				•			•						•				
Washington	•			•				•			•						•				
Wayne	•		•																		•
Westchester	•	•							•				•								
Wyoming	•						•									•					•
Yates	•		•																		•
New Jersey	•	•																			

*Medicare-primary NYSHIP enrollees will be enrolled in this HMO's Medicare Advantage Plan. For more information about NYSHIP Medicare Advantage Plans, ask your agency Health Benefits Administrator for a copy of *Choices for 2010* for Retirees.

The Empire Plan
NYSHIP Code Number 001

This section summarizes benefits available under each portion of The Empire Plan as of January 1, 2010[1]. You may also visit https://www.cs.state.ny.us, or call toll free 1-877-7-NYSHIP (1-877-769-7447), the one number for The Empire Plan carriers. Call to connect to:

The Empire Plan Medical Benefits Program

UnitedHealthcare

Medical and surgical coverage through:

- **Participating Provider Program** – More than 160,000 physicians and other providers participate; certain services are subject to a $15 or $20 copayment, depending on your group.
- **Basic Medical Program** – If you use a non-participating provider. See Cost Sharing (page 6) for an explanation of reimbursement under The Empire Plan Basic Medical Program.
- **Basic Medical Provider Discount Program** – If you use a non-participating provider who is part of The Empire Plan MultiPlan group (see pages 6 and 7).

Home Care Advocacy Program (HCAP) – Paid-in-full benefit for home care, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes. Diabetic shoes have an annual maximum benefit of $500. Guaranteed access to network benefits nationwide. Limited non-network benefits available. (See the *Empire Plan Certificate/Reports* for details).

Managed Physical Medicine Program – Chiropractic treatment and physical therapy through a Managed Physical Network (MPN) provider are subject to a $15 or $20 copayment, depending on your group. Unlimited network benefits when medically necessary. Guaranteed access to network benefits nationwide. Limited non-network benefits available.

Under **The Empire Plan Benefits Management Program**, you must call UnitedHealthcare for certification before an elective (scheduled) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or Nuclear Medicine test unless you are having the test as an inpatient in a hospital.

When arranged by UnitedHealthcare, voluntary, paid-in-full Specialist Consultant Evaluation is available.

Voluntary outpatient Medical Case Management is available to help coordinate services for serious conditions.

The Empire Plan Hospital Benefits Program

Empire BlueCross BlueShield

The following benefit level applies when covered services are received at a BlueCross and BlueShield Association BlueCard® PPO **network hospital**:

- Medical or surgical inpatient stays are covered at no cost to you.
- Hospital outpatient and emergency care are subject to network copayments.
- When you use a network hospital, anesthesiology, pathology and radiology provider charges for covered hospital services are paid in full under the Medical Benefits Program if The Empire Plan provides your primary coverage.
- Certain covered outpatient hospital services provided at network hospital extension clinics are subject to hospital outpatient and emergency care copayments. Other provider charges will be paid in full if using a network provider. Non-network provider charges will be paid in accordance with the Basic Medical portion of the Medical Benefits Program.

The following benefit level applies for services received at **non-network hospitals** *(for Empire Plan-primary enrollees only[2])*:

- Non-network hospital inpatient stays and outpatient services – 10 percent coinsurance[3] up to an annual maximum of $1,500 per enrollee; per spouse or domestic partner; per all dependent children combined. Up to $500 of the coinsurance may be reimbursed under the Basic Medical Program.

The Empire Plan will approve network benefits at a non-network facility if:

- Your hospital care is emergency or urgent.
- You do not have access to a network facility within 30 miles of your residence.
- No network facility can provide the medically necessary services.
- Another insurer or Medicare provides your primary coverage (pays first).

Preadmission Certification Requirements

Under The Empire Plan Benefits Management Program, if The Empire Plan is your primary coverage, you must call Empire BlueCross BlueShield for certification of any inpatient stay:

- Before a maternity or scheduled (non-emergency) hospital admission,
- Within 48 hours after an emergency or urgent hospital admission, and
- Before admission or transfer to a skilled nursing facility.

If you do not follow the preadmission certification requirement, you must pay:

- A $200 hospital deductible if it is determined any portion was medically necessary, and
- All charges for any day determined not to be medically necessary.

Voluntary inpatient Medical Case Management is available to help coordinate services for serious conditions.

The Empire Plan Mental Health and Substance Abuse Program

UnitedHealthcare/OptumHealth

The Empire Plan Mental Health and Substance Abuse Program offers two levels of benefits. If you call OptumHealth before you receive services and follow their recommendations, you receive:

Network Benefits
(unlimited when medically necessary)

- Inpatient (paid in full)
- Crisis intervention (up to three visits per crisis paid in full)
- Outpatient including office visits, home-based or telephone counseling and nurse practitioner services $15 or $20 copayment, depending on your group.
- Outpatient rehabilitation to an approved Structured Outpatient Rehabilitation Program for substance abuse subject to a $15 or $20 copayment, depending on your group.

If you do **NOT** follow the requirements for network coverage, you receive:

Non-Network Benefits[4]
(unlimited when medically necessary)

- For Practitioner Services: OptumHealth will consider up to 80 percent of reasonable and customary charges for covered services after you meet the applicable mental health care annual deductible and the applicable substance abuse annual deductible for outpatient practitioner services per enrollee; per

spouse or domestic partner; per all dependent children combined[5]. After the applicable coinsurance maximum is reached per enrollee, per spouse or domestic partner, per all dependent children combined[5], the Plan pays up to 100 percent of reasonable and customary charges for covered services.

- For Approved Facility Services: You are responsible for 10 percent coinsurance up to an annual maximum of $1,500 per enrollee; per spouse or domestic partner; per all dependent children combined. Each coinsurance maximum is applied as follows:
  - You pay the first $500 of coinsurance, then
  - The Program reimburses you for the next $500 of coinsurance, upon written request of the enrollee, then
  - You pay the final $500 of coinsurance.

  After the coinsurance maximum is met, the Plan pays 100 percent of billed charges for covered services.

Outpatient treatment sessions for family members of an alcoholic, alcohol abuser or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

Note: The amount you pay for inpatient and outpatient services does **NOT** count toward meeting your Basic Medical deductible or Basic Medical and non-network hospital coinsurance maximum. Deductibles, coinsurance and maximum coinsurance amounts are separate and not combined with any other deductible, coinsurance or maximum coinsurance amounts.

The Empire Plan Prescription Drug Program

UnitedHealthcare/Medco Health Solutions

- When you use a participating retail pharmacy or the mail service pharmacy for up to a 30-day supply of a covered drug, you pay a $5 copayment for Level 1 or generic drugs, $15 copayment for Level 2 or preferred brand-name drugs and $40 copayment for Level 3 or non-preferred brand-name drugs.
- For a 31- to 90-day supply of a covered drug through a participating retail pharmacy, you pay a $10 copayment for Level 1 or generic drugs, $30 copayment for Level 2 or preferred brand-name drugs and $70 copayment for Level 3 or non-preferred brand-name drugs.
- For a 31- to 90-day supply of a covered drug through the mail service pharmacy, you pay a $5 copayment for Level 1 or generic drugs, $20 copayment for Level 2 or preferred brand-name drugs and $65 copayment for Level 3 or non-preferred brand-name drugs.
- When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 or non-preferred brand-name copayment plus the difference in cost between the brand-name drug and the generic equivalent, not to exceed the full retail cost of the drug. Exceptions apply. Please contact your agency HBA for more information.
- The Empire Plan has a flexible formulary that excludes a small number of brand-name drugs from coverage (does not apply to CSEA, Courts, Council 82, ALESU, NYSCOPBA (Contract Affected)). Coverage for prescription drugs excluded under The Empire Plan benefit plan design are not subject to exception.
- Prior authorization is required for certain drugs.
- A pharmacist is available 24 hours a day to answer questions about your prescriptions.
- You can use a non-participating pharmacy or pay cash at a participating pharmacy (instead of using your Empire Plan benefit card) and fill out a claim form for reimbursement. In almost all cases, you will not be reimbursed the total amount you paid for the prescription, and your out-of-pocket expenses may exceed the usual copayment amount. To reduce your out-of-pocket expenses, use your Empire Plan benefit card whenever possible.

[1] These benefits are subject to medical necessity and to limitations and exclusions described in the *Empire Plan Certificate* and *Empire Plan Reports/Certificate Amendments*.
[2] If Medicare or another plan provides primary coverage, you receive network benefits for covered services at both network and non-network hospitals.
[3] Greater of 10 percent or $75 for outpatient.
[4] You are responsible for obtaining OptumHealth certification for care obtained from a non-network practitioner or facility.
[5] Annual deductibles and coinsurance maximums vary by group. See page 8 for details.

The Empire Plan NurseLine℠

Provides 24-hour access to health information and support.

Empire Plan Benefits Are Available Worldwide

The Empire Plan gives you the freedom to choose a participating provider or a non-participating provider.

Teletypewriter (TTY) numbers

For callers who use a TTY device because of a hearing or speech disability. All TTY numbers are toll free.

UnitedHealthcare
TTY only: 1-888-697-9054

Empire BlueCross BlueShield
TTY only: 1-800-241-6894

OptumHealth
TTY only: 1-800-855-2881

The Empire Plan Prescription Drug Program
TTY only: 1-800-759-1089

The Empire Plan Centers of Excellence Programs

The Centers of Excellence for Cancer Program includes paid-in-full coverage for cancer-related expenses received through Cancer Resource Services (CRS). CRS is a nationwide network including many of the nation's leading cancer centers. The enhanced benefits, including travel reimbursement, are available only when you are enrolled in the Program.

The Centers of Excellence for Transplants Program provides paid-in-full coverage for services covered under the Program and performed at a qualified Center of Excellence. The enhanced benefits, including travel reimbursement, are available only when you are enrolled in the Program and The Empire Plan is your primary coverage. Precertification is required.

Infertility Centers of Excellence are a select group of participating providers contracted by UnitedHealthcare and recognized as leaders in reproductive medical technology and infertility procedures. Benefits are paid in full, subject to the lifetime maximum benefit of $50,000. A travel allowance is available. Precertification is required.

For details on The Empire Plan Centers of Excellence Programs, see the *Empire Plan Certificate/Reports* and *Reporting on Centers of Excellence* available at https://www.cs.state.ny.us or from your agency HBA.

The Empire Plan

Benefits	Network Hospital Benefits[1]	Participating Provider	Non-Participating Provider
Office Visits		$15 or $20/visit[2]	Basic Medical[3]
Specialty Office Visits		$15 or $20/visit[2]	Basic Medical[3]
Diagnostic/Therapeutic Services			
Radiology	$40/outpatient visit	$15 or $20/visit[2]	Basic Medical[3]
Lab Tests	$40/outpatient visit	$15 or $20/visit[2]	Basic Medical[3]
Pathology	No copayment	$15 or $20/visit[2]	Basic Medical[3]
EKG/EEG	$40/outpatient visit	$15 or $20/visit[2]	Basic Medical[3]
Radiation, Chemotherapy, Dialysis	No copayment	No copayment	Basic Medical[3]
Women's Health Care/OB GYN			
Pap Tests	$40/outpatient visit	$15 or $20/visit[2]	Basic Medical[3]
Mammograms	$40/outpatient visit	$15 or $20/visit[2]	Basic Medical[3]
Pre and Postnatal Visits		No copayment	Basic Medical[3]
Bone Density Tests	$40/outpatient visit	$15 or $20/visit[2]	Basic Medical[3]
Family Planning Services		$15 or $20/visit[2]	Basic Medical[3]
Infertility Services	$40/outpatient visit	$15 or $20/visit[2]; No copayment at designated Centers of Excellence[4] ($50,000 lifetime allowance for Qualified Procedures)	Basic Medical[3]
Contraceptive Drugs and Devices (also covered under The Empire Plan Prescription Drug Program[5] subject to drug copayment)		$15 or $20/visit[2]	Basic Medical[3]
Emergency Room	$60 or $70/visit[2]	No copayment	Basic Medical[3,6]
Urgent Care		$15 or $20/visit[2]	Basic Medical[3]
Ambulance	No copayment[7]	$35 copayment	$35 copayment
Mental Health Practitioner Services		$15 or $20/visit[2] (OptumHealth)	Applicable annual deductible[2], 80% of reasonable and customary; after applicable coinsurance max[2], 100% of reasonable and customary (See pages 17-18 for details.)
Approved Facility Mental Health Services		No copayment; unlimited when medically necessary (OptumHealth)	90% of billed charges; after $1,500 coinsurance max, covered in full (See pages 17-18 for details.)
Outpatient Drug/Alcohol Rehabilitation		$15 or $20/visit[2] to approved Structured Outpatient Rehabilitation Program; unlimited when medically necessary (OptumHealth)	Applicable annual deductible[2], 80% of reasonable and customary; after applicable coinsurance max[2], 100% of reasonable and customary (See pages 17-18 for details.)
Inpatient Drug/Alcohol Rehabilitation		No copayment; unlimited when medically necessary (OptumHealth)	90% of billed charges; after $1,500 coinsurance max, covered in full (See pages 17-18 for details.)
Durable Medical Equipment		No copayment (HCAP)	50% of network allowance (See the *Empire Plan Certificate/Reports*)
Prosthetics		No copayment[8]	Basic Medical[3,8] $1,500 lifetime maximum benefit for prosthetic wigs
Orthotic Devices		No copayment[8]	Basic Medical[3,8]

External Mastectomy Prostheses			Covered in full benefit for one single or double prosthesis per calendar year under Basic Medical, not subject to deductible or coinsurance[3,8] (precertification may be required)
Rehabilitative Care – Acute Care Facility	No copayment when an inpatient; $15 or $20/visit[2] for outpatient physical therapy following related surgery or hospitalization	Physical or occupational therapy $15 or $20/visit (MPN)[2] Speech therapy $15 or $20/visit[2]	$250 annual deductible, 50% of network allowance $1,500 annual maximum benefit Basic Medical[3]
Diabetic Supplies		No copayment (HCAP)	50% of network allowance (See the *Empire Plan Certificate/Reports*)
Insulin and Oral Agents (covered under The Empire Plan Prescription Drug Program subject to drug copayment)			
Hospice	No copayment, no limit		
Skilled Nursing Facility	No copayment up to 365 benefit days[4] No benefits if Medicare-primary		
Prescription Drugs (see page 18)			
Additional Benefits			
Dental (preventive)		Not covered	Not covered
Vision (routine only)		Not covered	Not covered
Hearing Aids		Up to $1,200 or $1,500 per aid per ear every 4 years (every 2 years for children) if medically necessary	Up to $1,200 or $1,500 per aid per ear every 4 years (every 2 years for children) if medically necessary
Diabetic Shoes		$500 annual maximum benefit	75% of network allowance up to an annual maximum benefit of $500 (See the *Empire Plan Certificate/Reports*)
Out of Area Benefit	Under The Empire Plan, your benefits are the same wherever you receive care.		
Inpatient Hospital	No copayment[4]	No copayment	Basic Medical[3]
Outpatient Surgery[9]	$40 or $60 per visit[2]	$15 or $20/visit[2]	Basic Medical[3]
24-hour NurseLine℠ for health information and support			
Voluntary Disease Management Programs available for conditions such as asthma, attention deficit hyperactivity disorder (ADHD), cardiovascular disease, chronic kidney disease (CKD), chronic obstructive pulmonary disease, congestive heart failure, depression, diabetes and eating disorders.			
Diabetes Education Centers available to enrollees who have a diagnosis of diabetes.			

1 Services provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association. Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical Benefits Program. Non-network hospital coverage provided subject to coinsurance (see page 9).
2 Copayments, annual deductibles, coinsurance maximums and/or some benefits vary depending on your group.
3 See page 6 for an explanation of reimbursement under the Basic Medical Program.
4 Preadmission certification required.
5 Coverage excludes contraceptive intrauterine devices (IUDs) that do not contain any FDA-approved hormone prescription drug products.
6 Attending emergency room physicians and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and/or pathology services are paid in full. Other providers covered subject to deductible and coinsurance.
7 If service is provided by admitting hospital.
8 Benefit paid up to cost of device meeting individual's functional need.
9 In outpatient surgical locations, the copayment for the facility charge is $40 or $60 per visit or Basic Medical benefits apply depending upon the status of the center. (Check with the center or The Empire Plan carriers.)

Turning promise into practice®

Benefits	Enrollee Cost
Office Visits	$20 per visit
Non-Office Hours and Home Visits (by physician)	$25 per visit
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit
Lab Tests	$20 per visit
Pathology	$20 per visit
EKG/EEG	$20 per visit
Radiation	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	$20 per visit
Mammograms	No copayment
Pre and Postnatal Visits	$20 per visit (initial visit only)
Bone Density Tests	$20 per visit
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$50 per visit[1]
Urgent Care	$35 per visit
Ambulance	$50 per trip
Outpatient Mental Health unlimited visits	$20 per visit
Inpatient Mental Health unlimited days	No copayment
Outpatient Drug/Alcohol Rehab unlimited visits	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment

Benefits	Enrollee Cost
Durable Medical Equipment	20% coinsurance
Prosthetics	No copayment
Orthotics	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, unlimited	No copayment
Outpatient, max 60 consecutive days	$20 per visit
Diabetic Supplies	$20 per item
Insulin and Oral Agents	$20 per item
Hospice, unlimited	No copayment
Skilled Nursing Facility, unlimited	No copayment
Prescription Drugs	
Retail, 30-day supply	$10/$20/$35
Mail Order, 90-day supply	$20/$40/$70[2]

Coverage includes contraceptive drugs and devices, injectable and self-injectable medications, fertility drugs and enteral formulas.

Specialty Drugs

Specialty drugs are obtained through Aetna Specialty Pharmacy, which is our preferred specialty pharmacy provider for Aetna Pharmacy Management members. Aetna Specialty Pharmacy is wholly owned and operated by Aetna Inc. As a full-service specialty pharmacy, we do not charge for delivery or dispensing fees for injectables. Specialty drugs dispensed through Aetna Specialty Pharmacy are subject to our retail and mail order pharmacy copayment/coinsurance amounts, coverage limits and exclusions.

[1] Waived if admitted.

[2] Member communication materials will be mailed to the member upon enrollment explaining the mail order process and how to submit a mail order prescription.

Additional Benefits

Dental .....Not covered
Vision[3].....$20 per visit[4]
Hearing Aids.....Not covered
Diabetic Shoes, unlimited pairs[5] .....No copayment
Out Of Area .....While traveling outside the service area, coverage is provided for emergency situations only.
Eyeglasses.....Discount Program
Home Health Care (HHC)
unlimited (by HHC agency) .....No copayment
Outpatient Home Health Care
unlimited visits per 365-day period[6].....No copayment
Hospice Bereavement Counseling.....No copayment

[3] Routine only (including refraction)
[4] Frequency and age schedules apply.
[5] Medically necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot
[6] Four hours of home health aid equals one home care visit.

Plan Highlights for 2010

Aetna offers an array of quality benefits and a variety of special health programs for every stage of life; access to extensive provider and hospital networks in our multi-state service areas; emergency care covered worldwide; confidence in knowing that most of Aetna's mature HMOs have received the distinction of accreditation by the National Committee for Quality Assurance (NCQA).

Participating Physicians

Services are provided by local participating physicians in their private offices throughout Aetna's service area. Participating physicians are not employees of Aetna.

Affiliated Hospitals

Aetna members are covered at area hospitals to which their Aetna participating physician has admitting privileges. Aetna members may be directed to other hospitals to meet special needs.

Pharmacies and Prescriptions

Aetna members have access to an extensive network of participating pharmacies in all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. Aetna offers an **incented formulary**. Please refer to our formulary guide at www.aetna.com/formulary for prescriptions that require prior approval.

Medicare Coverage

Medicare-primary enrollees are required to enroll in Aetna's **Medicare Advantage Plan**, The Golden Medicare Plan.

NYSHIP Code Number 210

An IPA HMO serving individuals living or working in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan and Westchester counties in New York and all counties in New Jersey.

Aetna
99 Park Avenue
New York, NY 10016

For information:

Customer Service Department: 1-800-323-9930
TTY:1-800-654-5984
Medicare Advantage Customer Service:
1-800-282-5366
For Preenrollment Medicare Information
and a Medicare Packet:1-800-832-2640
Web site: www.aetna.com

Benefits	Enrollee Cost
Office Visits	$25 per visit
Routine Adult Physicals	$5 per visit
Well Child Care	No copayment
PCP visits for sick children to age 19	$5 per visit
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$40 per visit
Lab Tests	$25 per visit
Pathology	$25 per visit
EKG/EEG	$40 per visit
Radiation	$25 per visit
Chemotherapy	$25 for injection Rx and $25 office copayment. Max 2 copayments per day.
Women's Health Care/OB GYN	
Pap Tests[1]	$5 per visit
Mammograms	$5 per visit
Pre and Postnatal Visits	$5 per visit (first 10 visits only)
Bone Density Tests	$25 per visit
Family Planning Services	Applicable copayment applies
Infertility Services	Applicable copayment applies
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$100 per visit
Urgent Care	$35 per visit
Ambulance[2]	$100 per trip
Outpatient Mental Health unlimited visits	$40 per visit
Inpatient Mental Health unlimited days	No copayment
Outpatient Drug/Alcohol Rehab unlimited visits	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment
Durable Medical Equipment	50% coinsurance

Benefits	Enrollee Cost
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Physical, Speech, Occupational and Pulmonary Therapy max 30 visits combined	$40 per visit
Diabetic Supplies	$25 per item
Insulin and Oral Agents	$25 per item
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days per admission 360-day lifetime max	No copayment

Prescription Drugs

Retail, 30-day supply
$10 Tier 1/$30 Tier 2/$50 Tier 3[3]

Mail Order, up to 90-day supply
$20 Tier 1/$60 Tier 2/$100 Tier 3[3]

There is a separate copayment for each 30-day supply purchased at a retail pharmacy. You can order up to a 90-day supply through our mail order program with two copayments per 90-day supply. Coverage includes contraceptive drugs and devices and fertility drugs, injectable and self-injectable medications and enteral formulas.

Specialty Drugs

Designated specialty medications are covered only when purchased at a participating network specialty pharmacy. Medications purchased from a specialty pharmacy are subject to the same days supply and cost-sharing requirements that apply to the retail pharmacy benefit. Mail order does not apply and these medications cannot be filled at mail order.

A current list of specialty medications and participating specialty pharmacies is available on our web site at www.excellusbcbs.com.

[1] There are two services rendered for a Pap Test – the professional service by the OB GYN and the lab exam of the pap smear. There is a $5 copayment for the OB GYN exam, while the pap smear test is covered in full. NYSHIP members will see a $5 copayment for the "Pap Test."

[2] Air ambulance coverage is excluded.

[3] Should a doctor select a brand-name drug when an FDA-approved generic equivalent is available, the member will have to pay the difference between the cost of the generic and the brand-name plus any applicable copayments.

Additional Benefits

Dental .....Not covered
Vision .....$40 for exams associated with disease or injury only
Hearing Aids.....Children to age 19: $600 max, every 3 years
Diabetic Shoes
up to 3 pairs per calendar year.....No copayment
Out Of Area.....Our BlueCard and Away From Home Care Programs provide routine and urgent care coverage while traveling, for students away at school, members on extended out-of-town business and for families living apart.
Surgery
Physician-inpatient.....Lesser of $200 copayment or 20% coinsurance
Physician-outpatient at a hospital, facility or surgery center .....$40 copayment
Physician's office .....Lesser of $50 copayment or 20% coinsurance
Outpatient Surgical Care (Facility) .....$50 copayment
Maternity
Physician's charge for delivery .....Lesser of $200 copayment or 20% coinsurance

Plan Highlights for 2010

With Blue Choice, count on us to deliver the high-quality coverage you want and the value you need. Rely on Blue Choice for discounts on services that encourage you to develop a healthy lifestyle.

- Two copayments for up to a 90-day supply for prescription drugs through PrimeMail.
- Well child care is covered in full.
- Pay a $5 copayment for PCP visits for sick children to age 19.
- Pay a $5 copayment for preventive services such as adult routine physicals, mammograms, OB GYN exams and prostate screenings.

Participating Physicians

With over 3,200 providers available, Blue Choice offers you more choice of doctors than any other area HMO. Talk to your doctor about whether Blue Choice is the right plan for you.

Affiliated Hospitals

All operating hospitals in the Blue Choice service area are available to you. Others outside the service area are also available. Please call the number to the right for a directory, or check our web site at: www.excellusbcbs.com.

Pharmacies and Prescriptions

Blue Choice members may have their prescriptions filled at any of our over 60,000 participating pharmacies nationwide. Simply show the pharmacist your ID card. Blue Choice offers an **incented formulary**. Call PrimeMail at 1-866-260-0487 for mail order prescriptions. Fertility, injectable and self-injectable prescription drugs are covered.

Medicare Coverage

Medicare-primary enrollees are required to enroll in Medicare Blue Choice, the Excellus BlueCross BlueShield **Medicare Advantage Plan**. To qualify, you must be enrolled in Medicare Parts A and B and live in one of the counties listed below. Once you become eligible for Medicare, some of your Medicare Blue Choice copayments will vary from the copayments of NYSHIP-primary enrollees. Please call the Medicare Blue Choice number below for further details.

NYSHIP Code Number 066

A Network HMO serving individuals living or working in Livingston, Monroe, Ontario, Seneca, Wayne and Yates counties.

Blue Choice
165 Court Street
Rochester, NY 14647

For information:

Blue Choice: 585-454-4810 or 1-800-462-0108
TTY: 1-877-398-2282
Medicare Blue Choice: 1-877-883-9577
Web site: www.excellusbcbs.com

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Annual Gynecological Exams	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit[1]
Lab Tests	$20 per visit[1]
Pathology	$20 per visit[1]
EKG/EEG	$20 per visit
Radiation	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	No copayment
Bone Density Tests	$20 per visit
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$50 per visit
Urgent Care	$25 per visit
Ambulance	$50 per trip
Outpatient Mental Health unlimited visits	$20 per visit
Inpatient Mental Health unlimited days	No copayment
Outpatient Drug/Alcohol Rehab unlimited visits	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics[2]	50% coinsurance

Benefits	Enrollee Cost
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Short-term Physical and Occupational Therapy max 30 visits each per calendar year	$20 per visit
Outpatient Short-term Speech Therapy max 20 visits per calendar year	$20 per visit
Diabetic Supplies	
Retail, up to 30-day supply	$15 per item
Mail Order, up to 90-day supply	Two and a half copayments
Insulin and Oral Agents	
Retail, up to 30-day supply	$15 per item
Mail Order, up to 90-day supply	Two and a half copayments
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 generic/ $30 formulary brand/$50 non-formulary
Mail Order, 90-day supply	Two and a half copayments

Coverage includes contraceptive drugs and devices, injectable and self-injectable medications, fertility drugs and enteral formulas. Over-the-counter drugs listed on the CDPHP formulary are subject to the generic copayment. Have you considered using a generic? Generic drugs are required by law to meet the same standards as their brand-name counterparts at a fraction of the price. They must have the same strength, purity and stability. Generics are safe and effective for most conditions. Talk with your doctor about generic alternatives.

Specialty Drugs

Certain specialty prescriptions require prior approval, are subject to clinical management programs and must be filled by a CDPHP-participating specialty pharmacy vendor. It is easy to contact Caremark Specialty Pharmacy Services at 1-800-237-2767. A representative will collect your information, coordinate with your doctor and CDPHP and arrange delivery of your medications. For more information, visit Rx Corner at www.cdphp.com. Specialty drugs are subject to the same copayment tiers as other prescription drugs.

[1] No copayment for specific diagnostic services at preferred radiology or designated laboratory sites.
[2] Excludes shoe inserts.

Additional Benefits

Dental .....Not covered
Vision .....Not covered
Hearing Aids .....Not covered
Diabetic Shoes, one pair per calendar year.....$15 per pair
Out Of Area .....Coverage for emergency care out-of-area. College students are also covered for preapproved follow-up care.
Allergy Injections .....No copayment
Outpatient Surgery Facility .....$75 per visit
Diabetes Self-management Education .....$20 per visit
Glucometer .....$15 per item

Plan Highlights for 2010

Our dedicated member services representatives are available to respond to your questions Monday through Friday, 8 a.m. to 8 p.m. Our commitment goes beyond providing first-rate customer service. We want to help you remain healthy and assist you in reaching your wellness goals. To help you achieve this, as a CDPHP member, you can take advantage of a vast array of free wellness classes, such as spinning, Yoga, Pilates and many more. Staying up-to-date with routine checkups can help prevent unexpected illness and emergencies. Preventive care services are part of your CDPHP plan, at no cost to you. Take advantage of a 20 percent CVS discount. CDPHP partners with CVS Caremark to offer members extra savings on commonly used health products. Each subscriber receives three key tags, entitling them to a 20 percent discount on such CVS-brand health-related products as ibuprofen, decongestants, contact lens supplies, bandages and more. Do you have questions on an upcoming surgery or need advice on managing your diabetes or high blood pressure? Contact a health coach 24/7 through Health Coach Connection. Enroll in our Weigh 2 Be Program and receive a 50 percent rebate on a completed 10-week Weight Watchers session.

Participating Physicians

CDPHP is now affiliated with nearly 10,000 participating practitioners and providers.

Affiliated Hospitals

CDPHP is proud to be affiliated with most major hospitals within our service area. Members are cared for within the CDPHP network, unless an out-of-network facility or a Center of Excellence is approved for special care needs.

Pharmacies and Prescriptions

CDPHP offers an **incented formulary**. Prescriptions may be filled nationwide at any participating pharmacy. Rx Corner at www.cdphp.com enables members to log in and view claims history and research cost-saving alternatives. Save money by using mail order. Find forms online or call Member Services at 518-641-3700 or 1-800-777-2273. Certain prescriptions require prior approval, and specialty drugs for a few serious conditions are subject to clinical management programs and must be delivered by a CDPHP-participating specialty pharmacy vendor.

Medicare Coverage

Medicare-primary enrollees must enroll in the CDPHP **Medicare Advantage Plan**, the Group Medicare Choice plan. You must be enrolled in Medicare Parts A and B to qualify. For further details, please see *Choices for 2010* for Retirees of New York State and Participating Employers.

NYSHIP Code Number 063

An IPA HMO serving individuals living or working in Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

NYSHIP Code Number 300

An IPA HMO serving individuals living or working in Broome, Chenango, Delaware, Essex, Hamilton, Herkimer, Madison, Oneida, Otsego and Tioga counties.

NYSHIP Code Number 310

An IPA HMO serving individuals living or working in Dutchess, Orange and Ulster counties.

Capital District Physicians' Health Plan, Inc. (CDPHP)
500 Patroon Creek Boulevard
Albany, NY 12206-1057

For information:

Member Services: 518-641-3700 or 1-800-777-2273
TTY: 1-877-261-1164
Web site:www.cdphp.com

Benefits	Enrollee Cost
Office Visits	$10 per visit
Well Child Care	No copayment
Specialty Office Visits	$10 per visit
Diagnostic/Therapeutic Services	
Radiology	$10 per visit
Lab Tests	No copayment[1]
Pathology	No copayment
EKG/EEG	$10 per visit
Radiation	$10 per visit
Chemotherapy	$10 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment[2]
Pre and Postnatal Visits	No copayment[3]
Bone Density Tests	$10 per visit
Family Planning Services	$10 per visit
Infertility Services	$10 per visit[4]
Contraceptive Drugs and Devices	
Approved generic oral contraceptives covered at 100%	
Emergency Room	$50 per visit
Urgent Care	$10 per visit
Ambulance	$50 per trip
Outpatient Mental Health	
unlimited visits[5]	$10 per visit
Inpatient Mental Health	
unlimited days[5]	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited visits[5]	$10 per visit
Inpatient Drug/Alcohol Rehab	
unlimited days[5]	No copayment
Durable Medical Equipment	20% coinsurance
Prosthetics	20% coinsurance
Orthotics	20% coinsurance

Benefits	Enrollee Cost
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient, max 20 visits	$10 per visit
Diabetic Supplies	$10 per item
Insulin and Oral Agents	$10 per item
Hospice, unlimited	No copayment
Skilled Nursing Facility, max 50 days	No copayment

Prescription Drugs

Retail, 30-day supply — $5 generic/ $15 formulary brand/$35 non-formulary

Mail Order, 90-day supply — $15 generic/ $45 formulary brand/$105 non-formulary

Coverage includes contraceptive drugs and devices, prenatal vitamins and vitamins with fluoride, fertility drugs, injectable/self-injectable medications, enteral formulas, insulin and oral diabetic agents. Most injectable drugs are subject to prior approval. Member communication materials will be mailed to the member upon enrollment explaining the mail order process and how to submit a mail order prescription.

Specialty Drugs

Specialty drugs are available through mail order at the applicable copayment.

[1] For services at a stand-alone lab (must use Quest) or outpatient hospital that participates as a Quest Diagnostics hospital draw site. Lab services performed in conjunction with outpatient surgery or an emergency room visit will also be paid in full.

[2] Routine only

[3] $10 copayment will only be taken on the initial office visit to confirm the pregnancy.

[4] For services to diagnose and treat infertility.

[5] Subject to medical necessity.

Additional Benefits

Dental[6] .....20% discount at select providers, free second annual exam
Vision .....VisionPLUS Program (details below)
Hearing Aids.....Not covered
Diabetic Shoes.....Not covered
Out Of Area .....Worldwide coverage for emergency and urgent care through the BlueCard Program, a network of BlueCross and BlueShield providers across the country and around the world. Guest membership for routine care away from home that enables members on extended business trips or family members away at school to join a nearby Blue HMO and enjoy the same benefits they do at home.
VisionPLUS Program .....Community Blue members are entitled to a complete eyecare program that includes routine eye exams and discounts from participating VisionPLUS providers. Discounts included on frames, lenses, contact lenses and supplies.
Artificial Insemination .....20% coinsurance[7]

[6] Preventive
[7] Other artificial means to induce pregnancy (in-vitro, embryo transfer, etc.) are not covered.

Plan Highlights for 2010

Members have access to our BlueLife wellness programs, which provide innovative wellness and health management programs through online and community-based resources. Discounts are available on acupuncture, massage therapy, nutritional counseling, fitness centers and spas. Members also have access to a 24/7 patient advocacy program – Health Advocate – which assists patients with locating providers and scheduling appointments and offers a variety of other services.

Participating Physicians

Community Blue has over 3,000 physicians and health care professionals in our network who see patients in their private offices throughout our service area.

Affiliated Hospitals

Community Blue contracts with all Western New York hospitals to provide health care services to our members. Community Blue members may be directed to other hospitals to meet special needs when medically necessary.

Pharmacies and Prescriptions

Community Blue members may obtain prescriptions from a nationwide network of nearly 45,000 participating pharmacies. Prescriptions are filled for up to a 30-day supply (including insulin) when filled at a participating pharmacy. Community Blue offers an **incented formulary**. Member's copayment will reflect $5 formulary generic, $15 formulary brand, $35 non-formulary prescriptions. Enrollees may also take advantage of the convenience of obtaining a 90-day supply of their medications through mail order.

Medicare Coverage

Medicare-primary enrollees are required to enroll in Senior Blue HMO, the Community Blue **Medicare Advantage Plan**. To qualify you must be enrolled in Medicare Parts A and B and live in one of the counties listed below.

NYSHIP Code Number 067

An IPA HMO serving individuals living or working in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties.

Community Blue
The HMO of BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, NY 14240-0080

For information, call

Buffalo: 716-887-8840 or 1-877-576-6440
Olean: 716-376-6000 or 1-800-887-8130
Jamestown: 716-484-1188 or 1-800-944-2880
TTY: 1-888-249-2583
Web site: www.bcbswny.com

Benefits	Enrollee Cost
Office Visits	$20 per visit
webVisit	$5 copayment per online consultation
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	No copayment
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	No copayment
Chemotherapy	No copayment
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$50 per visit[1]
Urgent Care	$20 per visit
Ambulance	No copayment
Outpatient Mental Health	
unlimited visits	$20 per visit
Inpatient Mental Health	
unlimited days	No copayment
Outpatient Drug/Alcohol Rehab	$20 per visit (visits 1-52), then covered in full
Inpatient Drug/Alcohol Rehab	
max 30 days	No copayment
Durable Medical Equipment[2]	No copayment
Prosthetics[2]	No copayment
Orthotics[2]	No copayment

Benefits	Enrollee Cost
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 30 days	No copayment
Outpatient Physical Therapy, max 30 visits combined	
Home or Office	$20 per visit
Outpatient Facility	No copayment
Outpatient Speech/Language, Occupational and Vision Therapy, max 30 visits combined	
Home or Office	$20 per visit
Outpatient Facility	No copayment
Diabetic Supplies when obtained through EBCBS's medical supply vendor. When obtained through a pharmacy, supplies are subject to the applicable prescription drug copayments.	No copayment
Insulin and Oral Agents	Applicable Rx copayment applies
Hospice, max 210 days	No copayment
Skilled Nursing Facility,[2] max 60 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 generic/$20 brand/ $40 non-formulary per prescription
Mail Order, 90-day supply	$20 generic/$40 brand/ $80 non-formulary per prescription
More information available under Pharmacies and Prescriptions.	
Specialty Drugs Specialty medications are only dispensed in 30-day supplies. Enrollees are required to pay the applicable copayment for each 30-day supply.	

[1] Waived if admitted within 24 hours.

[2] Empire's network provider must precertify in-network services, or services may be denied; Empire network providers cannot bill members beyond in-network copayment (if applicable) for covered services. For ambulatory surgery, preapproval is required for cosmetic/reconstructive procedures, outpatient transplants and ophthalmological or eye-related procedures.

Additional Benefits

Dental .....Not covered
Vision .....Not covered
Hearing Aids .....Not covered
Diabetic Shoes, unlimited pairs[3] .....No copayment
Out Of Area.....Coverage for members traveling outside the service area may be available through the Guest Membership and/or BlueCard Programs. Guest Membership offers temporary coverage through the local BlueCross and/or BlueShield HMO plan. Contract holders are eligible for Guest Membership if away from home for more than 90 days, but less than 180 days. Full-time students and other eligible dependents are eligible for Guest Membership if away from home for more than 90 days. Coverage is available through the BlueCard Program for an enrollee traveling outside of the service area who may encounter an urgent or emergent situation and is not enrolled in the Guest Membership Program.

[3] Diabetic shoes are covered in full, with no member liability, so long as deemed medically appropriate and precertification is obtained from the participating vendor prior to purchase.

Plan Highlights for 2010

Empire BlueCross BlueShield HMO provides New York State employees located in our 28-county service area with a full range of benefits that include low out-of-pocket costs. Visit our state-of-the-art web site, www.empireblue.com, where your personal health care information is yours to manage any time of the day or night. You will instantly be able to find a list of your claims and payment status, email messages, your personal profile and health care provider information. Empire BlueCross BlueShield HMO earned the highest level of accreditation (Excellent) from the National Committee for Quality Assurance (NCQA).

Participating Physicians

Empire BlueCross BlueShield HMO provides access to a network of over 65,000 provider locations.

Affiliated Hospitals

Empire BlueCross BlueShield HMO members are covered through a comprehensive network of area hospitals (over 140) throughout our 28-county operating area to which their participating physician has admitting privileges. HMO members may be directed to other hospitals to meet special needs. Our provider directory and web site contain a list of all participating hospitals, including New York City hospitals.

Pharmacies and Prescriptions

Enrollees with prescription coverage can use local and national pharmacies. Members who use our mail service pay only two copayments for each 90-day supply of medication; a 33 percent savings over filling 90-day prescriptions at the retail level. Coverage includes contraceptive drugs and devices, injectable and self-injectable drugs, fertility drugs and enteral formulas. Empire BlueCross BlueShield HMO offers an **incented formulary**.

Medicare Coverage

Empire BlueCross BlueShield HMO **coordinates coverage** with Medicare and offers the same benefits to NYSHIP Medicare eligibles.

NYSHIP Code Number 280

An IPA HMO serving individuals living or working in Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

NYSHIP Code Number 290

An IPA HMO serving individuals living or working in Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk and Westchester counties.

NYSHIP Code Number 320

An IPA HMO serving individuals living or working in Dutchess, Orange, Putnam, Sullivan and Ulster counties.

Empire BlueCross BlueShield HMO
11 Corporate Woods Boulevard
P.O. Box 11800
Albany, NY 12211-0800

For information:

Empire BlueCross BlueShield HMO: 1-800-453-0113
TTY: 1-800-241-6894
Web site: www.empireblue.com

Benefits	Enrollee Cost
Office Visits	
Dependent Children 0-18	No copayment
Adults	$20 per visit
Specialty Office Visits[1]	
Dependent Children 0-18	No copayment
Adults	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit[2]
Lab Tests	No copayment[2]
Pathology	No copayment[2]
EKG/EEG	No copayment[2]
Radiation	No copayment[2]
Chemotherapy	No copayment[2]
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	No copayment
Bone Density Tests	$20 per visit
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$50 per visit[2]
Urgent Care	$35 per visit[2]
Ambulance[3]	$50 per trip[2]
Outpatient Mental Health	
unlimited visits	$20 per visit[2]
Inpatient Mental Health	
unlimited days	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited visits	$20 per visit[2]
Inpatient Drug/Alcohol Rehab	
unlimited days	No copayment

Benefits	Enrollee Cost
Durable Medical Equipment	20% coinsurance
Prosthetics	20% coinsurance
Orthotics	20% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient, max 30 visits combined	$20 per visit[2]
Diabetic Supplies, 30-day supply	$20 per item[2]
Insulin and Oral Agents	
Retail, 30-day supply	$20 per item
Mail Order, 90-day supply	$40 per item
Hospice, max 210 days	No copayment
Skilled Nursing Facility	
max 120 days per year	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 generic/ $20 preferred brand/$30 non-preferred brand
Mail Order, 90-day supply	$20 generic/ $40 preferred brand/$50 non-preferred brand

Coverage includes contraceptive drugs and devices, injectable and self-injectable medications, fertility drugs and enteral formulas.

Specialty Drugs

Specialty drugs are defined as injectable and non-injectable drugs that require frequent dosing amounts, intensive clinical monitoring or specialized product handling. Members are required to pay the copayment for each 30-day supply of specialty medication. No mail order benefit is available for specialty drugs.

[1] No Primary Care Physician (PCP) referral is required for GHI HMO participating providers.
[2] Copayment applies to all covered dependents.
[3] Air ambulance coverage is excluded.

Additional Benefits

Dental .....Not covered
Vision[4].....$20 per exam per year
Hearing Aids .....Not covered
Diabetic Shoes, unlimited pairs.....20% coinsurance
Out Of Area .....If you are out of the GHI HMO service area and experience a medical emergency, go to the nearest emergency facility for services. To receive non-emergent care, your PCP or the on-call physician must authorize your care as appropriate. In the event you are unable to reach your PCP, call GHI HMO Customer Service Department at 1-877-2GHI-HMO (1-877-244-4466) 24 hours a day, 7 days a week.

[4] Routine only

Plan Highlights for 2010

No PCP referrals are required for GHI HMO participating providers. Since 1937, GHI has been building a Statewide reputation for strength, stability and an extraordinary commitment to prompt, responsive service. As the largest not-for-profit health insurer in New York State, GHI introduced the GHI HMO in 1999. GHI HMO's provider network is available in 28 counties in New York State. GHI HMO's primary concern is to provide medical coverage that gives members confidence that they and their families are well covered. With more than three million Statewide members, GHI is committed to providing individuals, families and businesses with access to affordable, quality health care, supported by outstanding customer service.

Participating Physicians

Services are provided by participating physicians in their private offices. GHI HMO has over 21,000 member physicians and health care professionals throughout 28 counties in New York State. Please note: To enroll in GHI, NYSHIP members must live or work in one of the 15 NYSHIP-approved counties, however, once enrolled, they may use providers throughout GHI's 28-county service area.

Affiliated Hospitals

GHI HMO members are covered at area hospitals to which their GHI HMO physician has admitting privileges. GHI HMO members may be directed to other hospitals based on medical necessity when prior approval is obtained and the care is deemed appropriate by a GHI HMO Medical Director.

Pharmacies and Prescriptions

GHI HMO offers an **incented formulary**. Members may utilize any GHI HMO pharmacy for retail prescription drugs up to a 30-day supply. If a brand-name drug is selected or prescribed and there is a generic equivalent available, the member pays the brand copayment and the difference in price between the generic and the brand drug. All maintenance medication is obtained through the mail order program. For a complete list of prescriptions covered under our formulary, or for a list of prescriptions that require prior approval, go to www.ghi.com and click on "Pharmacy Plan" under Our Plans. For information regarding mail order drug benefits, or to set up your mail order account, contact Medco at 1-866-544-3772.

Medicare Coverage

GHI HMO offers the same benefits to NYSHIP Medicare eligibles. GHI HMO **coordinates coverage** with Medicare.

NYSHIP Code Number 220

An IPA HMO serving individuals living or working in Albany, Columbia, Delaware, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington counties.

NYSHIP Code Number 350

An IPA HMO serving individuals living or working in Dutchess, Orange, Putnam, Rockland, Sullivan and Ulster counties.

GHI HMO
789 Grant Avenue
Lake Katrine, NY 12449
or
GHI HMO
P.O. Box 4181
Kingston, NY 12401

For information:

Kingston: 1-877-244-4466
TTY: 1-877-208-7920
Web site: www.ghi.com

Benefits	Enrollee Cost
Office Visits	$5 per visit
Specialty Office Visits	$5 per visit
Diagnostic/Therapeutic Services	
Radiology	No copayment
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	No copayment
Chemotherapy	$5 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$5 per visit
Infertility Services[1]	Subject to applicable copayments
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$25 per visit
Urgent Care	$5 per visit
Ambulance	No copayment
Outpatient Mental Health unlimited visits	No copayment
Inpatient Mental Health unlimited days	No copayment
Outpatient Drug/Alcohol Rehab unlimited visits	$5 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment

Benefits	Enrollee Cost
Durable Medical Equipment	No copayment
Prosthetics	No copayment
Orthotics	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 30 days	No copayment
Outpatient, max 90 visits combined	$5 per visit
Diabetic Supplies	$5 per month
Insulin and Oral Agents	$5 per month
Hospice, max 210 days	No copayment
Skilled Nursing Facility, unlimited	No copayment
Prescription Drugs	
Retail, 30-day supply	$5
Mail Order, 90-day supply	$7.50

Subject to drug formulary, coverage includes contraceptive drugs and devices, fertility drugs, injectable and self-injectable medications and enteral formulas. Copayments are reduced by 50 percent when utilizing the HIP mail order service. Up to a 90-day supply of generic or brand-name drugs may be obtained.

Specialty Drugs
Coverage is provided through HIP's Specialty Pharmacy Program. Specialty drugs include injectables and oral agents that are more complex to administer, monitor and store in comparison to traditional drugs. Specialty drugs may require prior approval, which can be obtained through HIP pharmacy services by the HIP prescribing physician. Specialty drugs are subject to the applicable Rx copayment and Rx formulary.

[1] Includes the supplies and drugs related to the diagnosis and treatment of infertility.

Additional Benefits

Dental .....Not covered
Vision[2].....No copayment
Hearing Aids .....Covered for Cochlear Implants only
Diabetic Shoes, unlimited pairs[3] .....No copayment
Out Of Area .....Members are covered for emergency care both in and outside the HMO service area as well as with participating providers and non-participating providers.
Eyeglasses.....$45 per pair; one pair every 24 months from selected frames
Laser Vision Correction (LASIKS) .....Discount Program
Fitness Program.....Discount Program
Alternative Medicine Program .....Discount Program
Artificial Insemination .....$5 per visit
Prostate Cancer Screening .....Included in office visit copayment
Dialysis Treatment.....$10 per visit

[2] Routine only
[3] Diabetic shoes are covered in full with no member liability so long as deemed medically necessary and appropriate. Precertification must be obtained from the participating vendor prior to purchase.

Plan Highlights for 2010

HIP's network has expanded to over 29,000 providers in more than 50,000 locations. Plus, HIP offers more than 60 years of experience caring for union members and has the support of the New York State Central Labor Council. Our web site, www.hipusa.com, is available in English, Spanish, Chinese and Korean.

Participating Physicians

HIP offers the diversified choice of a traditional network of independent physicians who see patients in their own offices as well as providers in physician group practices that offer most, if not all of a member's medical needs under one roof. Group practices offer services in most major specialties such as cardiology, ophthalmology and orthopedics, as well as ancillary services like lab tests, X-rays and pharmacy services.

Affiliated Hospitals

HIP members have access to 104 of the area's leading hospitals, including major teaching institutions.

Pharmacies and Prescriptions

Filling a prescription is easy with HIP's network of over 40,000 participating pharmacies nationwide, including over 4,700 participating pharmacies throughout New York State. HIP also has a mail order program through Medco Health Solutions, Inc. HIP offers a **closed formulary**.

Medicare Coverage

HIP offers two plans to NYSHIP retirees. Retirees who are not Medicare-eligible are offered the same coverage as active employees. Medicare-primary retirees are required to enroll in HIP VIP Premier Medicare Plan, a **Medicare Advantage Plan** that provides Medicare benefits and more.

NYSHIP Code Number 050

A Network HMO serving individuals living or working in Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester counties.

HIP Health Plan of New York
55 Water Street
New York, NY 10041

For information:

1-877-861-0175
TTY: 1-888-447-4833
Web site: www.hipusa.com

Benefits	Enrollee Cost
Office Visits	$25 per visit
Well Child Care	No copayment
Routine Adult Physicals	$10 per visit
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$40 per visit
Lab Tests	$25 per visit
Pathology	$25 per visit
EKG/EEG	$40 per visit
Radiation	$25 per visit
Chemotherapy	$25 per visit
Women's Health Care/OB GYN	
Pap Tests	$10 per visit
Mammograms	$10 per visit
Pre and Postnatal Visits	$5 per visit (first 10 visits only), then covered in full
Bone Density Tests	$25 per visit
Family Planning Services	$25 per visit PCP/ $40 per visit specialist
Infertility Services	Applicable copayment applies
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$100 per visit
Urgent Care	$35 per visit
Ambulance[1]	$100 per trip
Outpatient Mental Health unlimited visits	$40 per visit
Inpatient Mental Health unlimited days	No copayment
Outpatient Drug/Alcohol Rehab unlimited visits	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment

Benefits	Enrollee Cost
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Physical, Speech, Occupational and Pulmonary Therapy max 30 visits combined	$40 per visit
Diabetic Supplies, 30-day supply	$25 per item
Insulin and Oral Agents, 30-day supply	$25 per item
Hospice, max 210 days	No copayment
Skilled Nursing Facility, max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier One/ $30 Tier Two/$50 Tier Three[2]
Mail Order, 90-day supply	$20 Tier One/ $60 Tier Two/$100 Tier Three[2]
Coverage includes contraceptive drugs and devices, injectable and self-injectable medications, fertility drugs and enteral formulas.	
Specialty Drugs Specialty medications after the initial first fill must be purchased from one of our participating specialty pharmacies.	

[1] Air ambulance coverage is excluded.

[2] Should a doctor select a brand-name drug (Tier Two or Tier Three) when an FDA-approved generic equivalent is available, the benefit will be based on the generic drug's cost, and the member will have to pay the difference, plus any applicable copayments. If your prescription has no approved generic available, your benefit will not be affected.

Additional Benefits

Dental .....Not covered
Vision .....$40 per visit for eye exams associated with disease or injury
Hearing Aids .....Children to age 19: $600 maximum, every three years
Diabetic Shoes
up to 3 pairs per calendar year .....50% coinsurance
Out Of Area.....Our BlueCard and Away From Home Care Programs provide routine and urgent care coverage while traveling, for students away at college, members on extended out-of-town business and families living apart.
Hearing Exam .....$40 per visit for routine (once every 12 months); $40 per visit for diagnostic
Surgery
Physician-inpatient .....lesser of $200 copayment or 20% coinsurance
Physician-outpatient at a hospital, facility or surgery center .....$40 copayment
Physician's office.....lesser of $50 copayment or 20% coinsurance
Outpatient Surgical Care (Facility) .....$50 copayment
Maternity
Physician charge for delivery.....lesser of $200 copayment or 20% coinsurance

Plan Highlights for 2010

- Expanded Customer Service Hours: Monday – Thursday: 7 a.m. – 7 p.m., Friday: 9 a.m. – 7 p.m., Saturday: 9 a.m. – 1 p.m.
- Well child care is covered in full.
- Pay only a $10 copayment for routine preventive services such as adult physicals, mammograms, pap smears, prostate screenings and routine adult immunizations.
- Two copayments for a 90-day prescription drug supply through our mail order program.
- Blue365 offers access to discounts and savings on products and services for healthy lifestyles.
- Our web site makes it easy to do business with us, when it is convenient for you, 24 hours a day, 7 days a week.

Participating Physicians

HMOBlue is affiliated with more than 4,700 physicians and health care professionals.

Affiliated Hospitals

All hospitals within our designated service area participate with HMOBlue. Members may be directed to other hospitals to meet special needs when medically necessary.

Pharmacies and Prescriptions

HMOBlue members may purchase prescription drugs at any participating pharmacy in the FLRx Network. This network has over 60,000 pharmacies nationwide. Specialty medications after the initial fill must be purchased from one of our participating specialty pharmacies. HMOBlue offers an **incented formulary**.

Medicare Coverage

HMOBlue offers the same benefits to NYSHIP Medicare eligibles. HMOBlue **coordinates coverage** with Medicare.

NYSHIP Code Number 072

An IPA HMO serving individuals living or working in Broome, Cayuga, Chemung, Cortland, Onondaga, Oswego, Schuyler, Steuben, Tioga and Tompkins counties.

HMOBlue
Excellus BlueCross BlueShield
Central New York Region
333 Butternut Drive
Syracuse, NY 13214

For information:

1-800-447-6269
TTY: 1-877-398-2275
Web site: www.excellusbcbs.com

NYSHIP Code Number 160:

An IPA HMO serving individuals living or working in Chenango, Clinton, Delaware, Essex, Franklin, Fulton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego and St. Lawrence counties.

HMOBlue
Excellus BlueCross BlueShield
Utica Region
12 Rhoads Drive
Utica, NY 13502

For information:

1-800-722-7884
TTY: 1-877-398-2275
Web site: www.excellusbcbs.com

Benefits	Enrollee Cost
Office Visits	$10 per visit
Specialty Office Visits	$10 per visit
Diagnostic/Therapeutic Services	
Radiology	$15 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$10 per visit
Radiation	$15 per visit
Chemotherapy	$10 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$10 per visit
Infertility Services	$10 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$50 per visit
Urgent Care	$10 per visit[1]
Ambulance	$50 per trip
Outpatient Mental Health unlimited visits	$10 per visit
Inpatient Mental Health unlimited days	No copayment
Outpatient Drug/Alcohol Rehab unlimited visits	$10 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment
Durable Medical Equipment	50% coinsurance

Benefits	Enrollee Cost
Prosthetics	No copayment
Orthotics[2]	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient, max 20 visits combined per year	$15 per visit
Diabetic Supplies	
Retail, 30-day supply	$10 per item
Mail Order	Not available
Insulin and Oral Agents	$10 per item or applicable pharmacy rider, whichever is less
Hospice, unlimited	No copayment
Skilled Nursing Facility, max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 tier I, most generic drugs/ $15 tier II, most preferred brand-name drugs/ $30 tier III, all other drugs
Mail Order, 90-day supply	2.5 copayments for maintenance drugs

Coverage includes contraceptive drugs and devices, injectable and self-injectable medications, fertility drugs and enteral formulas. Tier I oral contraceptives covered in full.

Specialty Drugs

Benefits are provided for specialty drugs by two contracted specialty pharmacy vendors, Curascript Pharmacy and OptionCare Pharmacy. Specialty drugs, available through the prescription drug benefit, include select high-cost injectables and oral agents such as oral oncology drugs. Specialty drugs require prior approval and are subject to the applicable Rx copayment based on the formulary status of the medication. Members pay one copayment for each 30-day supply.

[1] Within the service area. Outside the service area - $10 copayment plus the difference in cost between Independent Health's payment and the provider's charges, if any. $35 per visit to a participating After Hours Care Facility.

[2] Excludes shoe inserts.

Additional Benefits

Dental[3] .....$50 per cleaning and 20% discount on additional services at select providers
Vision[4] .....$10 per visit once every 12 months
Hearing Aids .....Discounts available at select locations
Diabetic Shoes
one pair per calendar year .....No copayment
Out Of Area .....While traveling outside the service area, members are covered for emergency and urgent care situations only.
Home Health Care, max 40 visits .....$10 per visit
Eyeglass lenses .....$35/single vision lenses; Frames 50% off retail price up to $130 and member pays 80% of balance over $130 (if any).
Urgent Care in Service Area for After Hours Care .....$35 per visit

[3] Preventive
[4] Routine only

Plan Highlights for 2010

Independent Health has led the way in providing Western New York with innovative solutions that set the standard for quality and service for health plans. We've consistently earned top ratings from NCQA, which is why you can feel comfortable and confident choosing us for your health coverage needs.

Participating Physicians

Independent Health is affiliated with over 3,000 physicians and health care providers throughout the eight counties of Western New York.

Affiliated Hospitals

Independent Health members are covered at all Western New York hospitals to which their physicians have admitting privileges. Members may be directed to other hospitals when medically necessary.

Pharmacies and Prescriptions

Over 350 pharmacies including many national chains. Members may obtain prescriptions out of the service area by using our National Pharmacy Network. Independent Health offers an **incented formulary**.

Medicare Coverage

Independent Health Medicare-primary retirees must enroll in Medicare Encompass, a **Medicare Advantage Plan**. Copayments will differ from the copayments of a NYSHIP-primary enrollee. Call for detailed information.

NYSHIP Code Number 059

An IPA HMO serving individuals living or working in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties.

Independent Health
511 Farber Lakes Drive
Buffalo, NY 14221

For information:

Customer Service: 1-800-501-3439
TTY: 716-631-3108
Web site: www.independenthealth.com

Benefits	Enrollee Cost
Office Visits	$20 per visit
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$20 per visit
Radiation	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	$20 per visit
Mammograms	No copayment[1]
Pre and Postnatal Visits	$20 per visit (initial visit only)
Bone Density Tests	$20 per visit
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Emergency Room	$50 per visit
Urgent Care	$20 per visit
Ambulance	No copayment
Outpatient Mental Health unlimited visits	$20 per visit
Inpatient Mental Health unlimited days	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab unlimited visits	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited days	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 2 months per condition	No copayment
Outpatient Physical, Speech and Occupational Therapy max 30 visits combined	$20 per visit
Diabetic Supplies	$20 copayment per boxed item for a 31-day supply
Insulin and Oral Agents	$20 copayment per boxed item for a 31-day supply
Hospice, max 210 days	No copayment
Skilled Nursing Facility, max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 generic/ $30 brand/$50 non-formulary
Mail Order, 90-day supply	$20 generic/ $60 brand/$100 non-formulary

Coverage includes fertility, injectable and self-injectable medications, contraceptive drugs and devices and enteral formulas subject to the limitations listed above and in your certificate of coverage.

Specialty Drugs
MVP uses CuraScript, a specialty pharmacy services company. Specific copayments are listed above. Refer to www.curascript.com for additional information.

[1] In a hospital setting. $20 per visit in an office setting.

Additional Benefits

Dental .....$25 per visit, children to age 19
Vision[2] .....$20 per exam/24 months
Hearing Aids .....Not covered
Diabetic Shoes, unlimited pairs.....50% coinsurance
Out Of Area .....While traveling outside the service area, coverage is provided for emergency situations only.

[2] Routine only

Plan Highlights for 2010

No referrals required! See any specialist in the MVP network without a referral. As an MVP member, you can enjoy significant savings on a wide variety of health-related items, plus special discounts on LASIK Eye Surgery, Alternative Medicine and Health and Fitness Centers! MVP's Health Management Programs offer help to members who need guidance and support to improve their chronic health conditions. Please visit our web site at www.mvphealthcare.com to learn more about these innovative programs.

Participating Physicians

MVP Health Care provides services through more than 27,500 participating physicians and health practitioners located throughout its service area.

Affiliated Hospitals

MVP members are covered at participating area hospitals to which their MVP physician has admitting privileges. MVP members may be directed to other hospitals to meet special needs when medically necessary upon prior approval from MVP.

Pharmacies and Prescriptions

Virtually all pharmacy "chain" stores and many independent pharmacies within the MVP service area participate with the MVP prescription drug program. Also, MVP offers convenient mail order service for select maintenance drugs. MVP offers an **incented formulary**.

Medicare Coverage

Medicare-primary enrollees located in the East Region (060) and the Central Region (330) must enroll in the MVP Gold Plan, MVP Health Care's **Medicare Advantage Plan**. Some of the MVP Gold Plan's copayments may vary from the MVP HMO Plan's copayments. Please contact our member services department for further details. The MVP HMO plan coordinates coverage with Medicare in the Mid-Hudson Region (340) and the North Region (360).

NYSHIP Code Number 060 (East)

An IPA HMO serving individuals living or working in Albany, Columbia, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

NYSHIP Code Number 330 (Central)

An IPA HMO serving individuals living or working in Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins counties.

NYSHIP Code Number 340 (Mid-Hudson)

An IPA HMO serving individuals living or working in Dutchess, Orange, Putnam, Rockland, Sullivan and Ulster counties.

NYSHIP Code Number 360 (North)

An IPA HMO serving individuals living or working in Franklin and St. Lawrence counties.

MVP Health Care
P.O. Box 2207
625 State Street
Schenectady, NY 12301-2207

For information:

Customer Service: 1-888-MVP-MBRS (687-6277)
TTY: 1-800-662-1220
Web site: www.joinmvp.com

Benefits	Enrollee Cost
Office Visits	$20 per visit
PCP Sick Visits for Children age 0-4	No copayment
PCP Sick Visits for Children age 5-18	$10 per visit
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit
Lab Tests	$5 per day
Pathology	$5 per day
EKG/EEG	$20 per visit
Radiation	No copayment
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	$15 per visit
Mammograms	No copayment
Pre and Postnatal Visits	$50 copayment per pregnancy
Bone Density Tests	$20 per visit
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	No copayment
Emergency Room	$50 per visit
Urgent Care	$25 per visit
Ambulance	$50 per trip
Outpatient Mental Health	
unlimited visits	$20 per visit
Inpatient Mental Health	
unlimited days	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited visits	$20 per visit
Inpatient Drug/Alcohol Rehab	
unlimited days	No copayment

Benefits	Enrollee Cost
Durable Medical Equipment	20% coinsurance
Prosthetics	20% coinsurance
Orthotics	20% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, unlimited	No copayment
Outpatient, max 30 visits combined	$20 per visit
Diabetic Supplies	
Retail, 30-day supply	$20 per item
Mail Order, 90-day supply	$50 per item
Insulin and Oral Agents	
Retail, 30-day supply	$20 per item
Mail Order, 90-day supply	$50 per item
Hospice, unlimited	No copayment
Skilled Nursing Facility	
max 120 days/year; 360 days/life	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1/ $30 Tier 2/$50 Tier 3
Mail Order, up to 90-day supply	$20 Tier 1/ $60 Tier 2/$100 Tier 3

If a member requests a brand-name drug to the prescribed generic drug, he/she pays the difference between the cost of the generic and the brand-name plus the Tier 1 copayment. Coverage includes fertility drugs, injectable and self-injectable medications and enteral formulas. Approved prescription generic contraceptive drugs and devices and those without a generic equivalent are covered at 100 percent under retail and mail order.

Specialty Drugs

MVP Rochester works with CuraScript, a specialty pharmacy services company that provides specialty injectable medications to our members with chronic conditions to maximize their medication management. Prescriptions are delivered by next-day service to the member's home or office. Refer to www.curascript.com for additional information.

Additional Benefits

Dental .....Not covered
Vision.....$20 per visit for routine; $20 per visit for diagnostic
Hearing Aids.....$600 allowance/ three calendar years/up to age 19
Diabetic Shoes, unlimited pairs.....20% coinsurance
Out Of Area .....Coverage is provided for urgent and emergent care when traveling outside of the MVP Rochester service area.
Eye Wear.....20% discount
Home Health Care, max 40 visits .....$20 per visit
Acupuncture, max 10 visits.....50% coinsurance

Plan Highlights for 2010

MVP Rochester is not just an insurance plan – we're a health plan committed to helping you live well. We work closely with our community's physicians to make sure you receive the quality, value and service you should expect from a health plan. Below are just a few of the many reasons to choose MVP Rochester in 2010:

- Our Commercial HMO plans are rated among "America's Best Health Plans 2008-09" by *U.S. News & World Report* and the National Committee for Quality Assurance.
- No referral required! See any specialist in the MVP Network without a referral.
- Each MVP Rochester subscriber receives $50 HealthDollars to spend on health, wellness and fitness programs!

Participating Physicians

MVP Rochester takes the quality of your medical care seriously. That's why we make sure the more than 27,500 physicians and other health care professionals in our network have the proper training and licenses. We respect their knowledge – therefore, they are key to developing our medical policies. And, should a serious health problem arise, MVP Rochester will work closely with you and your doctor to make sure you get the care you need.

Affiliated Hospitals

MVP Rochester members are covered at area hospitals to which their participating physicians have admitting privileges. Members may be directed to other hospitals to meet special needs.

Pharmacies and Prescriptions

MVP Rochester offers an **incented formulary**. MVP Rochester members simply present their card at any pharmacy in our extensive network. At an out-of-network pharmacy, members pay their copayment plus the costs above the MVP Rochester network rate.

Medicare Coverage

Medicare-primary enrollees must enroll in the Gold Plan, MVP Rochester's **Medicare Advantage Plan**. Once you become eligible for Medicare, some of the Gold Plan's copayments will differ from the copayments of NYSHIP-primary enrollees. Please call for more details.

NYSHIP Code Number 058

An IPA HMO serving individuals living or working in Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates counties.

MVP Rochester
220 Alexander Street
Rochester, NY 14607

For information:

MVP Rochester's Member Services Department:
585-325-3113 or 1-800-950-3224
TTY: 585-325-2629
Web site: www.mvphealthcare.com

NYSHIP Online

NYSHIP Online is designed to provide you with targeted information about your NYSHIP benefits. Visit the New York State Department of Civil Service web site at https://www.cs.state.ny.us and click on Benefit Programs, then NYSHIP Online. Select your group if prompted. If the group at the top of the NYSHIP Online home page is not your employee group, be sure to choose Change Your Group.

If you do not have access to the internet, your local library may offer computers for your use.

Ask your agency HBA for a copy of the NYSHIP Online flyer that provides helpful navigation information.

Reminder: If you are an active or retired employee of New York State or are retired from a Participating Employer and a registered user of MyNYSHIP, you may change your option online during the Option Transfer Period. See your agency HBA if you have questions.

How to find answers to your benefit questions and gain access to additional important information:

- If you are an active State employee, contact your agency Health Benefits Administrator (HBA), usually located in your agency's Personnel Office.
- If you have questions regarding health insurance claims for The Empire Plan, call 1-877-7-NYSHIP (1-877-769-7447) toll free and choose the appropriate program on the main menu. HMO enrollees should contact their HMO directly.
- A comprehensive list of contact information for HBAs, HMOs, government agencies, Medicare and other important resources is available on NYSHIP Online in the Using Your Benefits section.

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It is the policy of the State of New York 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 the Department of Civil Service web site (https://www.cs.state.ny.us). Click on Benefit Programs then 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 agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division.

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Care has been taken to ensure the accuracy of the material contained in this booklet. However, the HMO contracts and the certificate of insurance from The Empire Plan carriers with amendments are the controlling documents for benefits available under NYSHIP.