Health Insurance

CHOICES

For 2012

for Unsettled Groups

For Employees of the State of New York who are in Negotiating Units that do **not** have agreements/awards with New York State effective October 1, 2011 or later, their Dependents, COBRA Enrollees with their NYSHIP Benefits and Young Adult Option Enrollees (Check with your agency Health Benefits Administrator or union if you are uncertain.)

NYSHIP
New York State Health Insurance Program

November 2011

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Information & Reminders

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 2012 and Deadline for Changing Plans

The Empire Plan and HMO rates for 2012 are mailed to your home and posted on our web site as soon as they are approved. 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.ny.gov 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 and Young Adult Option enrollees may contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico and the Virgin Islands).

See your agency HBA 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 HBA. 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, 2011

Pre-tax does not apply to COBRA and Young Adult Option enrollees.

Under the Pre-tax Contribution Program (PTCP), your health insurance premiums are deducted from your pay before taxes are taken out. This lowers your taxable income and increases your spendable income. 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.

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
- Elect After-Tax Deduction.

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 2012, see your agency HBA and complete a Health Insurance Transaction Form (PS-404) by November 30, 2011.

Your Biweekly Premium Contribution

The following does NOT apply to COBRA and Young Adult Option 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, 2012 rates will be mailed to your home and posted on our web site at https://www.cs.ny.gov. 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.

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 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 2012?

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 2012* 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 2012 or if you are planning to retire in the coming year and will be Medicare-eligible.

Comparing Your NYSHIP Options

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.

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.

NYSHIP's Young Adult Option

During the Option Transfer Period, eligible adult children of NYSHIP enrollees can enroll in the Young Adult Option and current Young Adult Option enrollees will be able to switch plans. This option allows unmarried, young adult children, up to age 30 to purchase their own NYSHIP coverage. The premium is the full cost Individual coverage for the option selected. For more information about the Young Adult Option, go to https://www.cs.ny.gov/yao and choose your group.

Benefits Provided by The Empire Plan and All NYSHIP HMOs

- 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

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.

*Some plans may exclude coverage for airborne ambulance services. See the individual plan pages in this booklet for exclusions.

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 2012, 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 2012* for Retirees, *Planning for Retirement, Medicare & NYSHIP* or *Medicare for Disability Retirees.*

The Empire Plan or a NYSHIP HMO

What's New in 2012?

The Empire Plan

- There are no copayments for oral chemotherapy drugs.
- There is a combined annual deductible amount for medical/surgical and mental health and substance abuse services and a combined coinsurance maximum for hospital, medical/surgical and mental health and substance abuse services.

NYSHIP HMOs

- Effective January 1, 2012, Empire BlueCross BlueShield HMO (NYSHIP Codes 280, 290 and 320) will offer its members a Medicare Advantage option.

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.

Continued on next page

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 or non-network facility, benefits for covered services are subject to a deductible and/or coinsurance. For medical/surgical and mental health and substance abuse services, The Empire Plan has a combined annual deductible* per enrollee, per enrolled spouse/domestic partner and per all dependent children combined. The combined deductible must be met before covered expenses under the Basic Medical Program and non-network expenses under the Mental Health and Substance Abuse Program can be reimbursed. The Managed Physical Medicine Program has a separate $250 deductible that is not included in the combined annual deductible.

After you satisfy the combined annual deductible, the Empire Plan pays 80 percent of the reasonable and customary charge for the Basic Medical Program and non-network practitioner services for Mental Health and Substance Abuse Program and 90 percent of covered services for non-network Hospital Program and approved facility services for Mental Health and Substance Abuse Program. You are responsible for the remaining 20 percent coinsurance and all charges in excess of the reasonable and customary charge.

The Empire Plan has a combined annual coinsurance maximum* per enrollee, per enrolled spouse/domestic partner and per all dependent children combined. After you reach the combined annual coinsurance maximum, you will be reimbursed up to 100 percent of the reasonable and customary charge. You are responsible for paying the provider and will be reimbursed by the Plan for covered charges.

The combined coinsurance maximum will be shared among the Basic Medical Program and non-network coverage under the Hospital Program and Mental Health and Substance Abuse Program. The Managed Physical Medicine Program and Home Care Advocacy Program do not have a coinsurance maximum.

* See page 8 for the combined annual deductible and coinsurance maximum amounts that apply to you, based on your employee group.

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 2012* flyer that will be mailed to your home and posted on our web site, https://www.cs.ny.gov, as soon as rates are approved. Along with this booklet, which provides copayment information, *NYSHIP Rates & Deadlines for 2012* 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 combined 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 Medical 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.ny.gov. 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. 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.ny.gov. 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 and facilities nationwide, and from more than 60,000 participating pharmacies across the United States or a mail service pharmacy.

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 may be 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 multispecialty 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 Deductibles and Coinsurance Maximums by Group*

Employee Group	Annual Deductible[1] (per enrollee; per enrolled spouse or domestic partner; per all enrolled dependent children combined)	Coinsurance Maximum[2]
ALESU[3]	$400 CPI[4]	$1,483 CPI[4]
Council 82	$400 CPI[4]	$882 CPI[4]
DC-37	$309 CPI[4]	$662 CPI[4]/$300[5]
NYSCOPBA	$400 CPI[4]	$854 CPI[4]
PBA – Supervisors	$400 CPI[4]	$882 CPI[4]
PBA – Troopers	$400 CPI[4]	$882 CPI[4]
PIA	$400 CPI[4]	$882 CPI[4]
UUP	$400 CPI[4]	$1,102 CPI[4]
UUP Lifeguards[3]	$400 CPI[4]	$1,483 CPI[4]

[1] The deductible amount applies to the covered expenses under the Basic Medical Program and the Mental Health and Substance Abuse Program, combined. The deductible must be met before your Basic Medical Program and/or Mental Health and Substance Abuse Program claims can be reimbursed.

[2] The coinsurance maximum is shared among the Basic Medical Program and non-network coverage under the non-network Hospital Program and Mental Health and Substance Abuse Program.

[3] Coinsurance maximum per contract (all other groups calculated as per enrollee; per enrolled spouse or domestic partner; per all enrolled dependent children combined).

[4] These changes reflect the 3.1% increase in the medical care component of the Consumer Price Index of Urban Wage Earners and Clerical Workers, all Cities (CPI-W) for the period of July 1, 2010 through June 30, 2011.

[5] The coinsurance maximum will be reduced to $300 for calendar year 2012 for employees in (or equated to) salary grade 6 or below on January 1, 2012.

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

*The Managed Physical Medicine Program has a separate $250 deductible that is not included in the combined annual deductible. The Managed Physical Medicine Program and Home Care Advocacy Program do not have a coinsurance maximum.

The Empire Plan and NYSHIP HMOs: Similarities and Differences

Can I use the hospital of my choice?

The Empire Plan:
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 the combined annual maximum per enrollee; per enrolled spouse or domestic partner; per all enrolled dependent children combined (see page 8).

NYSHIP HMOs:
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?

The Empire Plan:
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.)

NYSHIP HMOs:
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?

The Empire Plan:
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].

NYSHIP HMOs:
Yes. As long as you follow HMO requirements and receive the appropriate referral, your copayment (or coinsurance) should be your only expense.

Will I be covered for care I receive away from home?

The Empire Plan:
Yes. Under The Empire Plan, your benefits are the same wherever you receive care.

NYSHIP HMOs:
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?

The Empire Plan:
You have guaranteed access to unlimited medically necessary care when you follow Plan requirements.

NYSHIP HMOs:
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?

The Empire Plan:
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.

NYSHIP HMOs:
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. (Coverage for diabetic shoes does not apply to employees of the State of New York represented by PBANYS in the Agency Law Enforcement Services Unit (ALESU) or UUP employees in lifeguard titles.)

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).

Making a Choice

Selecting a health insurance plan is an important personal decision. Only you know your family lifestyle, health, budget and benefit preferences. 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? 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 be for health care?
- 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?

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.

How to Use the *Choices* Benefit Charts, Pages 16 – 41

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, 2012. See plan documents for complete information on benefit limitations.

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.ny.gov, 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.

Note: 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.

If You Decide to Change Your Plan

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 plan:

- See your agency HBA before the Option Transfer Period 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.

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 2012.

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.ny.gov; click on Benefit Programs, then on NYSHIP Online. Select your group if prompted, and then click on Find a Provider.
- Ask your agency HBA 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 2012 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 or open formulary** encourages use of preferred drugs to non-preferred drugs based on a tiered copayment schedule. In a **flexible formulary**, 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): Individual 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.

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	40
	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	058	060	330	340	360
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	•														•				•		

*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 HBA for a copy of *Choices for 2012* 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	40
	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	058	060	330	340	360
Livingston	•		•														•				
Madison	•				•										•				•		
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 HBA for a copy of *Choices for 2012* for Retirees.

The Empire Plan NYSHIP Code #001

This section summarizes benefits available under each portion of The Empire Plan as of January 1, 2012[1]. You may also visit https://www.cs.ny.gov, 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 Medical/Surgical Program

UnitedHealthcare

Medical and surgical coverage through:

- **Participating Provider Program** – More than 275,000 physicians and other providers participate; certain services are subject to a $15, $18, or $20 copayment, depending on your group.
- **Basic Medical Program** – If you use a non-participating provider, the Program considers up to 80 percent of reasonable and customary charges for covered services after the combined annual deductible is met. After the combined annual coinsurance is met, the Plan pays up to 100 percent of reasonable and customary charges for covered services. See Cost Sharing (page 6) for additional information.
- **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[2]. 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, $18 or $20 copayment, depending on your group. Unlimited network benefits when medically necessary. Guaranteed access to network benefits nationwide. Non-network benefits available.

Under the **Benefits Management Program**, you must call the Medical Program 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 tests unless you are having the test as an inpatient in a hospital.

When arranged by the Medical/Surgical Program, voluntary, paid-in-full Specialist Consultant Evaluation is available.

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

The Hospital 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/Surgical 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/Surgical Program.

The following benefit level applies for services received at **non-network hospitals** *(for Empire Plan-primary enrollees only[3])*:

- Non-network hospital inpatient stays and outpatient services – 10 percent coinsurance[4] up to the combined annual coinsurance maximum per enrollee; per enrolled spouse or domestic partner; per all enrolled dependent children combined[5].

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

- Before a maternity or scheduled (non-emergency) hospital admission,
- Within 48 hours or as soon as reasonably possible 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 penalty 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 Mental Health and Substance Abuse Program

UnitedHealthcare/OptumHealth

The Mental Health and Substance Abuse Program (MHSA) offers two levels of benefits. If you call the MHSA Program 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, $18 or $20 copayment, depending on your group.
- Outpatient rehabilitation to an approved Structured Outpatient Rehabilitation Program for substance abuse subject to a $15, $18 or $20 copayment, depending on your group.

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

Non-network Benefits[6]

(unlimited when medically necessary)

- For Practitioner Services: the MHSA Program will consider up to 80 percent of reasonable and customary charges for covered services after you meet the combined annual deductible per enrollee; per enrolled spouse or domestic partner; per all enrolled dependent children combined[5]. After the applicable coinsurance maximum is reached per enrollee, per enrolled spouse or domestic partner, per all enrolled 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[4] up to the combined annual maximum per enrollee; per enrolled spouse or domestic partner; per all enrolled dependent children combined[5]. 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 counts towards meeting the deductible or coinsurance maximum. Deductibles, coinsurance and maximum coinsurance amounts are combined with all other deductible, coinsurance or maximum coinsurance amounts.

The 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 $30[7]/$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 $65[7]/$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 $55[7]/$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.
- The Empire Plan has a flexible formulary[2] that excludes certain drugs from coverage. An excluded drug is not subject to any type of appeal or coverage review, including a medical necessity appeal.
- 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.
- The Prescription Drug Program's Specialty Pharmacy Program[2] offers enhanced services to individuals using specialty drugs, such as those used to treat complex conditions and those that require special handling, special administration, or intensive patient monitoring. (The complete list of specialty drugs included in the Specialty Pharmacy Program is available on the New York State Department of Civil Service web site at https://www.cs.ny.gov.) The Program provides enrollees with enhanced services that include disease and drug education, compliance management, side-effect management, safety management, expedited, scheduled delivery of medications at no additional charge, refill reminder calls and all necessary supplies such as needles and syringes applicable to the medication. Most specialty drugs are only covered when dispensed by The Empire Plan's designated specialty pharmacy, Accredo, a subsidiary of Medco. When Accredo dispenses a specialty medication, the applicable mail service copayment is charged. Specialty drugs can be ordered through the Specialty Pharmacy Program using the Medco mail order form. To request mail service envelopes, refills or to speak to a specialty-trained pharmacist or nurse regarding the Specialty Pharmacy Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) between 8 a.m. and 8 p.m. Monday through Friday, choose the Prescription Drug Program, and ask to speak with Accredo.

[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] Benefit does not apply to employees of the State of New York represented by PBANYS in ALESU and UUP employees in lifeguard titles.

[3] If Medicare or another plan provides primary coverage, you receive network benefits for covered services at both network and non-network hospitals.

[4] Greater of 10 percent or $75 for outpatient.

[5] Annual deductibles and coinsurance maximums vary by group. See page 8 for details.

[6] You are responsible for obtaining MHSA Program certification for care obtained from a non-network practitioner or facility.

[7] For employees of the State of New York represented by PBANYS in ALESU and UUP employees in lifeguard titles.

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.

Medical/Surgical Program
TTY only: 1-888-697-9054

Hospital Program
TTY only: 1-800-241-6894

Mental Health and Substance Abuse Program
TTY only: 1-800-855-2881

Prescription Drug Program
TTY only: 1-800-759-1089

Grandfathered Health Plans

Under the Patient Protection and Affordable Care Act (PPACA), a grandfathered health plan is permitted to preserve certain basic health coverage that was already in effect when the Act was signed into law on March 23, 2010. Being a grandfathered health plan means that the plan may delay implementation of certain features of health care reform that apply to non-grandfathered health plans. For example, the requirement for the provision of preventive health services without any cost sharing does not need to be included under a health care plan until the plan is no longer grandfathered. However, grandfathered health plans must comply with certain other consumer protections in the Act such as, the elimination of lifetime limits on certain benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the New York State Department of Civil Service Employee Benefits Division, Alfred E. Smith State Office Building, Albany, NY 12239. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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 a travel allowance, 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 a travel allowance, 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.ny.gov or from your agency HBA.

The Empire Plan

For employees of the State of New York who are in negotiating units that do not have agreements/awards with New York State effective 10/1/11 or later, their enrolled dependents and for COBRA and Young Adult enrollees with their NYSHIP benefits

Benefits	Network Hospital Benefits[1]	Participating Provider	Non-participating Provider
Office Visits		$15, $18 or $20 per visit[2]	Basic Medical[3]
Specialty Office Visits		$15, $18 or $20 per visit[2]	Basic Medical[3]
Diagnostic/Therapeutic Services			
Radiology	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]	Basic Medical[3]
Lab Tests	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]	Basic Medical[3]
Pathology	No copayment	$15, $18 or $20 per visit[2]	Basic Medical[3]
EKG/EEG	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]	Basic Medical[3]
Radiation, Chemotherapy, Dialysis	No copayment	No copayment	Basic Medical[3]
Women's Health Care/OB GYN			
Pap Tests	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]	Basic Medical[3]
Mammograms	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]	Basic Medical[3]
Pre and Postnatal Visits		No copayment	Basic Medical[3]
Bone Density Tests	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]	Basic Medical[3]
Family Planning Services		$15, $18 or $20 per visit[2]	Basic Medical[3]
Infertility Services	$30, $35 or $40/outpatient visit[2]	$15, $18 or $20 per visit[2]; No copayment at designated Centers of Excellence[4] ($50,000 lifetime allowance for Qualified Procedures)	Basic Medical[3]
Contraceptive Drugs and Devices (may also be covered under the Prescription Drug Program[5] subject to drug copayment)		$15, $18 or $20 per visit[2]	Basic Medical[3]
Inpatient Hospital Surgery	**Network Hospital:** No copayment; **Non-network Hospital/Non-participating Provider:** Hospital charges subject to 10% of billed charges up to coinsurance maximum. Non-participating Provider charges subject to Basic Medical		
Outpatient Surgery[6]	**Network Hospital/Participating Provider:** $35, $40 or $60 per visit; **Network Hospital/Non-participating Provider:** Hospital charges $35, $40 or $60 per visit. Non-participating Provider charges subject to Basic Medical; **Non-network Hospital/Non-participating Provider:** Hospital charges subject to 10% of billed charges or a $75 copayment, whichever is greater up to coinsurance maximum. Non-participating Provider charges subject to Basic Medical		
Emergency Room[7]	$50, $60 or $70/visit[2]	No copayment	Basic Medical[3,8]
Urgent Care		$15, $18 or $20 per visit[2]	Basic Medical[3]
Ambulance	No copayment[9]	$35 copayment[10]	$35 copayment[10]
Mental Health Practitioner Services		$15, $18 or $20 per visit[2] (MHSA)	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 (MHSA)	90% of billed charges; after coinsurance max, covered in full (See pages 17-18 for details.)
Outpatient Drug/Alcohol Rehabilitation		$15, $18 or $20 per visit[2] to approved Structured Outpatient Rehabilitation Program; unlimited when medically necessary (MHSA)	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 (MHSA)	90% of billed charges; after 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[11]	Basic Medical[3,11] $1,500 lifetime maximum benefit for prosthetic wigs[12]
Orthotic Devices		No copayment[11]	Basic Medical[3,11]
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[3,11] (precertification may be required)
Rehabilitative Care – Acute Care Facility	No copayment when an inpatient; $15, $18, $20 for outpatient physical therapy following related surgery or hospitalization	Physical or occupational therapy $15, $18 or $20 per visit[2] (MPN)[2] Speech therapy $15, $18 or $20 per visit[2]	$250 annual deductible, 50% of network allowance 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 Prescription Drug Program subject to drug copayment)			
Diabetic Shoes		$500 annual maximum benefit[12]	75% of network allowance up to an annual maximum benefit of $500 (See the *Empire Plan Certificate/Reports*)[12]
Hospice	No copayment, no limit		10% of billed charges up to coinsurance maximum
Skilled Nursing Facility	No copayment up to 365 benefit days[4]		
Prescription Drugs (see page 18)			
Specialty 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
Out of Area Benefit	Under The Empire Plan, your benefits are the same wherever you receive care.		
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.

2 Copayments, annual deductibles, coinsurance maximums and/or some benefits vary depending on your group.

3 See pages 6 and 7 (Cost Sharing).

4 Preadmission certification required.

5 Coverage excludes contraceptive intrauterine devices (IUDs) that do not contain any FDA-approved hormone prescription drug products.

6 In outpatient surgical locations (Medical/Surgical Program), the copayment for the facility charge is $15, $30 or $35 per visit or Basic Medical benefits apply depending upon the status of the center. (Check with the center or The Empire Plan carriers.)

7 Waived if admitted.

8 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.

9 If service is provided by admitting hospital.

10 Ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and the type of ambulance transportation is required because of an emergency situation.

11 Benefit paid up to cost of device meeting individual's functional need.

12 Benefit does not apply to employees of the State of New York in ALESU and UUP employees in lifeguard titles.

Aetna

Turning promise into practice®

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit
Lab Tests	No copayment
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	No copayment
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
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	No copayment
Physician's Office	No copayment
Outpatient Surgery Facility	No copayment
Emergency Room	$50 per visit[1]
Urgent Care	$35 per visit
Ambulance	$50 per trip
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit

Benefits	Enrollee Cost
Inpatient Mental Health	
unlimited	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited	$20 per visit
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
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
Diabetic Shoes	No copayment
unlimited pairs when medically necessary	
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.

Additional Benefits

Dental..... Not covered
Vision[3].....No copayment[4]
Hearing Aids..... Not covered
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[5].....No copayment
Hospice Bereavement Counseling.....No copayment

[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.
[3] Routine only (including refraction).
[4] Frequency and age schedules apply.
[5] Four hours of home health aid equals one home care visit.

Plan Highlights for 2012

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 and 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

Blue Choice
A product of Excellus BlueCross BlueShield, Rochester Region

Benefits	Enrollee Cost
Office Visits	$25 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
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	No copayment (routine); $5 copayment (diagnostic)
Mammograms	No copayment (routine); $5 copayment (diagnostic)
Pre and Postnatal Visits	$5 per visit (first 10 visits only)
Bone Density Tests	No copayment (routine); $5 copayment (diagnostic)
Family Planning Services	Applicable copayment applies
Infertility Services	Applicable copayment applies
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Inpatient Hospital Surgery	
Physician	Lesser of $200 copayment or 20% coinsurance
Facility	No copayment
Outpatient Surgery	
Hospital	$50 per visit
Physician's Office	Lesser of $50 copayment or 20% coinsurance
Outpatient Surgery Facility[1]	$50 per visit
Emergency Room	$100 per visit[2]
Urgent Care	$35 per visit
Ambulance	$100 per trip

Benefits	Enrollee Cost
Outpatient Mental Health	
Individual, unlimited	$40 per visit
Group, unlimited	$40 per visit
Inpatient Mental Health	
unlimited	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
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 and Occupational Therapy max 30 visits combined	$40 per visit
Diabetic Supplies	$25 for up to a 30-day supply
Insulin and Oral Agents	$25 for up to a 30-day supply
Diabetic Shoes	50% coinsurance
One pair per year when medically necessary	
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 purchase a 90-day supply for a maintenance medication at a retail pharmacy for a $30/$90/$150 copayment. You can order up to a 90-day supply through our mail order program with two copayments per 90-day supply. A 90-day supply is limited to a 30-day supply for the first fill. Coverage includes 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. 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.

Additional Benefits

Dental[4] ..... Not covered

Vision ..... $40 for exams associated with disease or injury only; routine not covered

Hearing Aids ..... Children to age 19: Covered in full for up to two hearing aids every three years

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.

Maternity (Physician's charge for delivery) ..... $50 copayment

[1] Outpatient Surgery Physician: $40 per visit.

[2] Waived if admitted within 24 hours.

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

[4] Covered only for accidental injury to sound and natural teeth and for care due to congenital disease or anomaly; $40 copayment.

Plan Highlights for 2012

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 per 90-day supply for prescription drugs purchased through PrimeMail.
- Pay a $5 copayment for PCP visits for sick children up to age 26.

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 provided 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 NYSHIP 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
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit[1]
Lab Tests	$20 per visit[2]
Pathology	$20 per visit[2]
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[3]
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
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$75 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$75 per visit
Emergency Room	$50 per visit[4]
Urgent Care	$25 per visit
Ambulance	$50 per trip
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit
Inpatient Mental Health	
unlimited	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited	$20 per visit

Benefits	Enrollee Cost
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics[5]	50% coinsurance
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
Diabetic Shoes	$15 per pair
one pair per year when medically necessary	
Hospice, max 210 days	No copayment
Skilled Nursing Facility	
max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 Tier 1/$30 Tier 2/$50 Tier 3
Mail Order, 90-day supply	Two and a half copayments

Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas. Over-the-counter drugs listed on the CDPHP formulary are subject to Tier 1 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.

Additional Benefits

Dental ..... Not covered
Vision ..... Not covered
Hearing Aids ..... Not covered
Out Of Area ..... Coverage for emergency care out of area. College students are also covered for preapproved follow-up care.
Allergy Injections ..... No copayment
Diabetes Self-management Education ..... $15 per visit
Glucometer ..... $15 per item

[1] Waived if provider is a preferred center.
[2] Waived if provider is a designated laboratory.
[3] $20 copayment (initial visit only) to confirm pregnancy.
[4] Waived if admitted within 24 hours.
[5] Excludes shoe inserts.

Plan Highlights for 2012

As a CDPHP member, you have coverage for emergency care no matter where you travel. Download our free Find-A-Doc mobile app and have our network provider listing at your fingertips. Visit www.cdphp.com and follow CDPHP on Facebook, Twitter, and LinkedIn. You can also get Health E-Updates sent via email for details on our many free wellness classes. Dedicated member services representatives are available weekdays from 8 a.m. to 8 p.m. to answer benefit questions. Interested in health coaching or wellness support? Call 1-888-94-CDPHP and a health expert will guide you to programs and services that fit your unique needs.

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** with a few select drugs or class of drugs that are not covered. 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 NYSHIP 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 2012* for Retirees.

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

Community Blue
BlueCross BlueShield of Western New York

Benefits	Enrollee Cost
Office Visits	$10 per visit
Annual Adult Routine Physicals	No copayment
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	No copayment
Family Planning Services[4]	See footnote
Infertility Services	$10 per visit[5]
Contraceptive Drugs and Devices[6]	See footnote
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$10 per visit
Physician's Office	$10 per visit
Outpatient Surgery Facility	$10 per visit
Emergency Room	$50 per visit[7]
Urgent Care	$10 per visit
Ambulance	$50 per trip
Outpatient Mental Health	
Individual, unlimited[8]	$10 per visit
Group, unlimited[8]	$10 per visit
Inpatient Mental Health	
unlimited[8]	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab	
unlimited[8]	$10 per visit
Inpatient Drug/Alcohol Rehab	
unlimited[8]	No copayment
Durable Medical Equipment	20% coinsurance
Prosthetics	20% coinsurance
Orthotics	20% coinsurance
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
Diabetic Shoes	Not covered
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 prenatal vitamins, vitamins with fluoride, fertility drugs, injectable/self-injectable medications, enteral formulas, insulin and oral diabetic agents. Most injectable drugs are subject to prior approval. Communication materials will be mailed to the member upon enrollment explaining the process and how to submit a mail order prescription.	
Specialty Drugs	
Available through mail order at the applicable copayment.	

Additional Benefits

Dental[9] ..... 20% discount at select providers, free second annual exam

Vision ..... VisionPLUS Program (details below)

Hearing Aids ..... Not covered

Out Of Area ..... Worldwide coverage for emergency and urgent care through the BlueCard Program. 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 for the same benefits.

VisionPLUS Program ..... Members are entitled to an eyecare program that includes a routine eye exam covered in full and discounts from participating VisionPLUS providers. Low copayments on frames, lenses and a discount on contact lenses and supplies.

Artificial Insemination ..... 20% coinsurance[10]

[1] For services at a stand-alone Quest lab 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 (initial visit only) to confirm pregnancy.

[4] Coverage is provided for diagnostic testing and procedures in conjunction with artificial insemination. The copayments, coinsurance and deductible under your Policy, which apply to hospital, medical or prescription drug benefits, are applicable to the benefits covered under family planning services.

[5] For services to diagnose and treat infertility.

[6] Coverage is provided for prescription drugs approved by the FDA for use in treatment associated with contraception.

[7] Waived if admitted.

[8] Subject to medical necessity.

[9] Preventive.

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

Plan Highlights for 2012

Members have access to 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.

Participating Physicians

Community Blue has over 3,000 physicians and healthcare 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. Members may be directed to other hospitals to meet special needs when medically necessary.

Pharmacies and Prescriptions

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) at a participating pharmacy. Community Blue offers an **incented formulary**.

Medicare Coverage

Medicare-primary NYSHIP 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:
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

Empire BLUECROSS BLUESHIELD

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology[1]	$20 per visit
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
Inpatient Hospital Surgery[2]	No copayment
Outpatient Surgery	
Hospital[2]	$75 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility[2]	$75 per visit
Emergency Room	$75 per visit[3]
Urgent Care	$20 per visit
Ambulance	No copayment
Outpatient Mental Health[2]	
Individual, unlimited	No copayment
Group, unlimited	No copayment
Inpatient Mental Health,[2] unlimited	No copayment
Outpatient Drug/Alcohol Rehab[2]	No copayment
Inpatient Drug/Alcohol Rehab[2]	
As many days as medically necessary	No copayment

Benefits	Enrollee Cost
Durable Medical Equipment[2]	20% coinsurance
Prosthetics[2]	20% coinsurance
Orthotics[2]	20% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 30 days	No copayment
Outpatient Physical Therapy up to 30 visits per calendar year combined between home, office, or outpatient facility	$20 per visit
Home or Office	$20 per visit
Outpatient Facility	$20 per visit
Outpatient Speech/Language, Occupational and Vision Therapy up to 30 visits per calendar year combined between home, office, or outpatient facility	$20 per visit
Home or Office	$20 per visit
Outpatient Facility	$20 per visit
Diabetic Supplies	$20 per item, For diabetic DME/supplies up to 52 combined items annually, then covered at 100%
Insulin and Oral Agents	$20 per item, For diabetic DME/supplies up to 52 combined items annually, then covered at 100%
Diabetic Shoes	$20 per pair Unlimited pairs when medically necessary for diabetic DME/supplies up to 52 combined items annually, then covered at 100%
Hospice, max 210 days	No copayment
Skilled Nursing Facility[2] max 60 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1/ $25 Tier 2/$50 Tier 3
Mail Order, 90-day supply	$20 Tier 1/ $50 Tier 2/$100 Tier 3
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.

Additional Benefits

Dental..... Not covered
Vision..... Not covered
Hearing Aids..... Not covered
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.

[1] For MRI/MRA, CAT, PET and Nuclear Cardiology services, 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.

[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.

[3] Waived if admitted within 24 hours.

Plan Highlights for 2012

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 healthcare 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 healthcare 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 injectable and self-injectable drugs, fertility drugs and enteral formulas. Empire BlueCross BlueShield HMO offers an **incented formulary**.

Medicare Coverage

Medicare-primary enrollees are required to enroll in MediBlue, the Empire 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.

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
For Medicare Advantage Plan
Preenrollment Information: 1-866-205-6551
TTY:1-800-241-6894
Web site: www.empireblue.com

GHI HMO

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits[1]	$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	No copayment
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	No copayment
Physician's Office	$20 per visit
Outpatient Surgery Facility	$75 per visit
Emergency Room	$50 per visit[2]
Urgent Care	$35 per visit[2]
Ambulance[3]	$50 per trip[2]
Outpatient Mental Health	
Individual, unlimited	$20 per visit[2]
Group, unlimited	$20 per visit[2]
Inpatient Mental Health	
unlimited	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab	
unlimited	$20 per visit[2]
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
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
Diabetic Shoes	20% coinsurance
unlimited pairs when medically necessary	
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
Subject to drug formulary, coverage includes fertility drugs, injectable and self-injectable medications 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.	

Additional Benefits

Dental..... Not covered
Vision[4].....$20 per exam per year
Hearing Aids..... Not covered
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-emergency 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.

[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.
[4] Routine only.

Plan Highlights for 2012

No referrals are required. Since 1937, GHI has been building a statewide reputation for strength, stability and an exceptional commitment to prompt, responsive service. As the largest not-for-profit health insurer in New York State, GHI introduced its HMO in 1999. GHI HMO's provider network is available in 28 counties in New York State. GHI HMO's primary goal is to provide medical coverage that gives members confidence that they and their families are well covered. GHI is committed to providing individuals, families and businesses with access to affordable, quality healthcare, with 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-name 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 Medicare-eligible NYSHIP enrollees. 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

HIP®
HEALTH PLAN OF NEW YORK
an EmblemHealth Company

Benefits	Enrollee Cost
Office Visits	$5 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
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[1]
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[2]	Applicable copayment applies
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	No copayment
Physician's Office	No copayment
Outpatient Surgery Facility	No copayment
Emergency Room	$25 per visit[3]
Urgent Care	$5 per visit
Ambulance	No copayment
Outpatient Mental Health	
Individual, unlimited	No copayment
Group, unlimited	No copayment
Inpatient Mental Health	
unlimited	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab	
unlimited	$5 per visit
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
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 prescription
Insulin and Oral Agents	$5 per prescription
Diabetic Shoes	No copayment
Covered when medically necessary. Precertification must be obtained from the participating vendor prior to purchase.	
Hospice, max 210 days	No copayment
Skilled Nursing Facility, unlimited	No copayment
Prescription Drugs	
Retail, 30-day supply	$5
Mail Order, 90-day supply[4]	$7.50
Subject to drug formulary, coverage includes fertility drugs, injectable and self-injectable medications and enteral formulas. Copayments are reduced by 50 percent when utilizing the EmblemHealth mail order service. Up to a 90-day supply of generic or brand-name drugs may be obtained.	
Specialty Drugs	
Coverage is provided through the EmblemHealth 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 the EmblemHealth pharmacy services by the HIP prescribing physician. Specialty drugs are subject to the applicable Rx copayment and Rx formulary.	

Additional Benefits

Dental..... Not covered
Vision[5].....No copayment
Hearing Aids.....Covered for cochlear implants only
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 (LASIK)..... Discount Program
Fitness Program..... Discount Program
Alternative Medicine Program..... Discount Program
Artificial Insemination.....$5 per visit
Prostate Cancer Screening.....No copayment
Dialysis Treatment.....$10 per visit

[1] Inpatient and outpatient visits.
[2] Includes the supplies and drugs related to the diagnosis and treatment of infertility.
[3] Waived if admitted.
[4] There is no copayment reduction for using mail order for non-formulary/non-preferred Tier 3 drugs.
[5] Routine only.

Plan Highlights for 2012

The HIP Prime network has expanded to over 29,000 providers in more than 61,000 locations. Plus, EmblemHealth 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, emblemhealth.com, is available in English, Spanish, Chinese and Korean.

Participating Physicians

The HIP Prime network 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 Prime members have access to over 100 of the area's leading hospitals, including major teaching institutions.

Pharmacies and Prescriptions

Filling a prescription is easy with EmblemHealth's network of over 40,000 participating pharmacies nationwide, including over 4,700 participating pharmacies throughout New York State. HIP Prime members have access to a mail order program through Express Scripts. The HIP Prime Plan offers a **closed formulary**.

Medicare Coverage

EmblemHealth 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 the VIP Premier (HMO) 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.

EmblemHealth
55 Water Street
New York, NY 10041

For information:
1-877-861-0175
TTY: 1-888-447-4833
Web site: emblemhealth.com

HMOBlue

A product of Excellus BlueCross BlueShield

An Independent Licensee of the BlueCross BlueShield Association

Benefits	Enrollee Cost
Office Visits	$25 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
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	No copayment
Mammograms	No copayment
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
Inpatient Hospital Surgery	Lesser of $200 copayment or 20% coinsurance
Outpatient Surgery	
Hospital	$40 per visit
Physician's Office	Lesser of $50 copayment or 20% coinsurance
Outpatient Surgery Facility	$50 per visit
Emergency Room	$100 per visit[1]
Urgent Care	$35 per visit
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$40 per visit
Group, unlimited	$40 per visit

Benefits	Enrollee Cost
Inpatient Mental Health	
unlimited	No copayment
Outpatient Drug/Alcohol Rehab	
unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
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 and Occupational 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
Diabetic Shoes	50% coinsurance
three pairs per year when medically necessary	
Hospice, max 210 days	No copayment
Skilled Nursing Facility	
max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1/$30 Tier 2/$50 Tier 3[2]
Mail Order, 90-day supply	$20 Tier 1/$60 Tier 2/$100 Tier 3[2]
Coverage includes 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. A current list of specialty medications and participating specialty pharmacies is available on our web site.	

Additional Benefits

Dental..... Not covered

Vision .....$40 per visit for eye exams associated with disease or injury

Hearing Aids..... Children to age 19: Covered in full for up to two hearing aids every three years, $40 copayment per visit for fittings

Out Of Area .....The 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

Maternity

Physician charge for delivery .....lesser of $200 copayment or 20% coinsurance

Smoking Cessation

Over the Counter (OTC) ..... Not covered

Prescription..... Contact us for details

Individual and Group Counseling ..... Contact us for details

[1] Emergency Room copayment waived if admitted as inpatient.

[2] Should a doctor select a brand-name drug (Tier 2 or Tier 3) when an FDA-approved generic equivalent is available, the benefit will be based on the generic drug's cost, and the member will pay the difference, plus any applicable copayments. If your prescription has no approved generic available, your benefit will not be affected.

Plan Highlights for 2012

- No referrals required.
- Customer Service Hours: Mon–Thurs: 7 a.m.–7 p.m., Fri: 9 a.m.–7 p.m., Sat: 9 a.m.–1 p.m.
- Inpatient hospital care is covered in full.
- Routine preventive services, such as adult physicals, mammograms, pap smears, prostate screenings and routine adult immunizations are covered in full.
- Two copayments for a 90-day Rx 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 Medicare-eligible NYSHIP enrollees. 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 13214-1803

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	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology[1]	$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	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$20 per visit
Infertility Services	
Physician's Office	$20 per visit
Outpatient Surgery Facility	$75 per visit
Contraceptive Drugs and Devices	Applicable Rx copayment applies
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$75 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$75 per visit
Emergency Room	$75 per visit[2]
Urgent Care	$50 per visit[3]
Ambulance	$75 per trip
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit
Inpatient Mental Health	
unlimited	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab	
unlimited	$20 per visit
Inpatient Drug/Alcohol Rehab	
unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	No copayment
Orthotics[4]	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient, max 20 visits combined per year	$20 per visit
Diabetic Supplies	
Retail, up to 30-day supply	$20 per item
Mail Order	Not available
Insulin and Oral Agents	$20 per item or applicable pharmacy rider, whichever is less
Diabetic Shoes one pair per year when medically necessary	No copayment
Hospice, unlimited	No copayment
Skilled Nursing Facility	
max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 Tier 1, most generic drugs/ $15 Tier 2, most preferred brand name drugs/ $30 Tier 3, non-preferred brand-name drugs
Mail Order, 90-day supply	Two and a half copayments for maintenance drugs
Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas. Tier 1 oral contraceptives covered in full.	

Specialty Drugs

Benefits are provided for specialty drugs by two contracted specialty pharmacy vendors, Reliance Rx Pharmacy and Walgreens Specialty 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.

Additional Benefits

Dental[5] ..... $50 per cleaning and 20% discount on additional services at select providers

Vision[6] ..... $10 per visit once every 12 months

Hearing Aids ..... Discounts available at select locations

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 ..... $20 per visit

Eyeglasses ..... $50/single vision lenses; Frames 40% off retail price

Urgent Care in Service Area for After Hours Care ..... $50 per visit

Wellness Services ..... $250 allowance for use at a participating facility

[1] Office based: $20 copayment; Hospital based: $40 copayment.

[2] Waived if admitted.

[3] Within the service area. Outside the service area: $20 copayment plus the difference in cost between Independent Health's payment and the provider's charges, if any. $50 per visit to a participating After Hours Care Facility.

[4] Excludes shoe inserts.

[5] Preventive.

[6] Routine only.

Plan Highlights for 2012

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 4,000 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

All retail pharmacies in Western New York participate. Members may obtain prescriptions out of the service area by using our National Pharmacy Network, which includes 57,000 pharmacies nationwide. Independent Health offers an **incented formulary**.

Medicare Coverage

Medicare-primary NYSHIP retirees must enroll in Medicare Encompass, a **Medicare Advantage Plan**. Copayments 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	$25 per visit[1]
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$25 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$25 per visit
Radiation	$40 per visit
Chemotherapy	$40 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Pre and Postnatal Visits	$25 per visit (initial visit only)
Bone Density Tests	No copayment
Family Planning Services	$25 per visit
Infertility Services	
PCP	$25 per visit
Specialist	$40 per visit
Contraceptive Drugs and Devices	No copayment
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$40 per visit
Physician's Office	$25 (PCP); $40 (specialist)
Outpatient Surgery Facility	$40 per visit
Emergency Room	$75 per visit[2]
Urgent Care	$25 per visit
Ambulance	$50 per trip
Outpatient Mental Health	
Individual, unlimited	$40 per visit
Group, unlimited	$40 per visit
Inpatient Mental Health	
unlimited	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab	
unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab	
unlimited	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	$40 per visit
Diabetic Supplies	$25 copayment per boxed item for a 31-day supply
Insulin and Oral Agents	$25 copayment per boxed item for a 31-day supply
Diabetic Shoes unlimited pairs when medically necessary	50% coinsurance
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	$25 generic/$75 brand/ $125 non-formulary

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, 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% under retail and mail order.

Specialty Drugs

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

Additional Benefits

Dental.....$25 per visit, children up to age 19 (preventive care)
Vision[3]..... $25 per exam/24 months
Hearing Aids..... Not covered
Out Of Area.....While traveling outside the service area, coverage is provided for emergency situations only.

[1] PCP Sick Visits for Children (newborn up to age 26) $10 per visit.
[2] Waived if admitted.
[3] Routine only.

Plan Highlights for 2012

Each MVP subscriber receives $100 HealthDollars to spend on health, wellness and fitness programs! 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, eyewear, alternative medicine and health and fitness center memberships! Please visit our web site at www.discovermvp.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 NYSHIP enrollees 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. The MVP HMO plan coordinates coverage with Medicare in the North Region (360). Please contact our Member Services Department for further details.

NYSHIP Code Number 058 (Rochester)
An IPA HMO serving individuals living or working in Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates counties.

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

Young Adult Option Web Site

This web site provides information about NYSHIP's Young Adult Option. It explains eligibility requirements, how to enroll and provides the rates for The Empire Plan and all NYSHIP HMOs. Go to https://www.cs.ny.gov/yao and choose your parent's employer group.

If you don't have access to the Internet, your local library may offer computers for your use.

NYSHIP
New York State Health Insurance Program

Young Adult Option Coverage

Choose your parent's employee group:

NY (with active or retiree benefits) ← **Choose your parent's employer group**

Employed by a New York State agency

PE (with active or retiree benefits)

Employed by a government agency in New York State such as the Thruway Authority or Metropolitan Transit Authority that is maintained and financed from special administrative funds and participates in NYSHIP

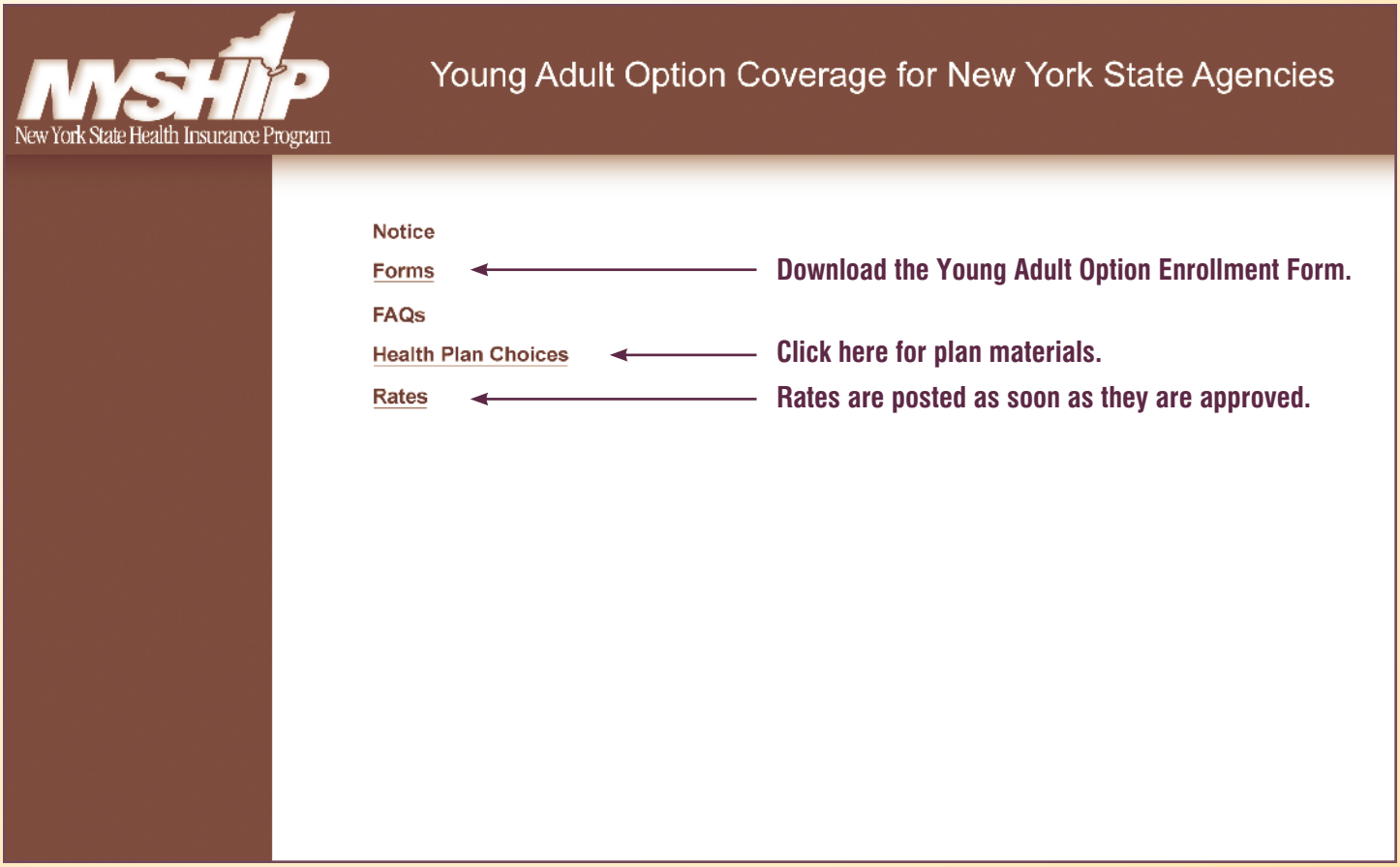
PA (with active or retiree benefits)

Employed by a city, town, municipality or school district in New York State that participates in NYSHIP

SEHP

A graduate student enrolled in the Student Employee Health Plan (SEHP)

From your group specific page, you can download enrollment forms, review plan materials and compare rates. This site is your best resource for information on NYSHIP's Young Adult Option. If you have additional questions, please contact the Employee Benefits Division at 518-474-5754 or 1-800-833-4344.



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.ny.gov 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 employee of New York State 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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nyshiponline

Current Topics | Health Benefits | Other Benefits | Using Your Benefits | Planning to Retire? | Find a Provider | Search | Calendar | What's New?

Your Group • Your Plan Change Your Group | Text Version | Text Adjust **Self-Service Login (MyNYSHIP)**

Using Your Benefits

Empire Plan Copayments

Telephone Numbers - General contact information for health and other benefits, benefit funds, and State and U.S. government.

Telephone Numbers

Publications - A library of recent publications related to your benefits.

Empire Plan Providers, Pharmacies and Services

Forms - Empire Plan Claims Forms and Non-Participating Provider Claims Forms and Administrative Forms.

2011 Empire Plan Drug List - Alphabetical Order | PDF Version

2011 Empire Plan Drug List - Therapeutic Class Order | PDF Version

Changes to Drug Lists and Notifications of Safety Issues

2011 At A Glance - Easy to access benefits summary that can answer most of your general questions.

Archived Publications

Health Benefits Administrators

Health Benefits Administrators

Format Options for Forms and Publications

Military Leave Benefit Extension for Employees of the State of New York

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New York State
Department of Civil Service
Alfred E. Smith State Office Building
Albany, NY 12239
https://www.cs.ny.gov

It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the Department of Civil Service web site (https://www.cs.ny.gov). 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 and Young Adult Option Enrollees: Contact the Employee Benefits Division.

Choices was printed using recycled paper and environmentally sensitive inks. NY0940 Choices 2012/Actives Unsettled

The New York State Department of Civil Service, which administers NYSHIP, produced this booklet in cooperation with NYSHIP carriers and Joint Labor/Management Committees on Health Benefits.

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.