NYSHIP
New York State Health Insurance Program

General Information & Book Empire Plan Certificate Amendments

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

June 2003

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

Keep these amendments with your August 1, 2001 *New York State Health Insurance Program General Information Book and Empire Plan Certificate.*
Pages in your Book/Certificate and later Certificate Amendments have consecutive numbers.

New York State Health Insurance Program General Information Book

Empire Plan Certificate Amendments

Empire Plan Certificate

Empire Blue Cross Blue Shield

United HealthCare

GHI/ValueOptions Mental Health and Substance Abuse Program

CIGNA/Express Scripts Prescription Drug Program

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

Where this document differs from your August 1, 2001 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports* and *Certificate Amendments,* this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Substitute the following for the fourth paragraph under "Your share of the premium" in the "Costs, ..." section on page 12 of your NYSHIP General Information Book.

Premium costs

Effective January 1, 2003. For the prescription drug component of your Empire Plan or HMO premium, the State pays 90 percent of your premium as the enrollee, plus 75 percent of the cost of dependent coverage regardless of the number of dependents.

Substitute the following for the first two sentences of the "Empire Blue Cross Blue Shield conversion" section in the "Changing from NYSHIP to a Direct-Pay Conversion Contract" on page 30 of your NYSHIP General Information Book as amended in your June 2002 Empire Plan Report.

Empire Blue Cross Blue Shield conversion

Conversion policies are available from Empire Blue Cross Blue Shield. Direct-payment hospital only coverage and basic medical coverage contracts are available to all enrollees.

Substitute the following for the first paragraph of "United HealthCare conversion" in the "Changing from NYSHIP to a Direct-Pay Conversion Contract" on page 30 of your NYSHIP General Information Book.

United HealthCare conversion

A direct-pay conversion policy for hospital/surgical/medical coverage is available from United HealthCare. However, there is no conversion right under United HealthCare for Empire Plan enrollees who have existing coverage which would duplicate the conversion coverage.

Substitute the following for "How to request direct-pay conversion contracts" in the "Changing from NYSHIP to a Direct-Pay Conversion Contract" on page 31 of your NYSHIP General Information Book.

Conversion contracts

Empire Blue Cross Blue Shield: To request a conversion policy, call or write to:

Empire Blue Cross Blue Shield
P.O. Box 1407
Church Street Station
New York, New York 10008-1407
1-800-261-5962

Or, if you live outside New York State and are eligible for Medicare, contact the local Blue Cross and Blue Shield office or other local insurance company in your state to apply for a direct-pay contract to supplement Medicare.

United HealthCare: To request a conversion policy for hospital/surgical/medical coverage, write to:

United HealthCare
P.O. Box 1600
Kingston, New York 12402-1600

EMPIRE PLAN CERTIFICATE

Substitute the following for the Empire Blue Cross Blue Shield, United HealthCare, ValueOptions, Express Scripts and the Empire Plan NurseLine℠ telephone numbers wherever the numbers appear in your Empire Plan Certificate.

NYSHIP number

1-877-7-NYSHIP (1-877-769-7447) toll free

EMPIRE BLUE CROSS BLUE SHIELD CERTIFICATE OF INSURANCE

Substitute the following heading for Section II on page 48 of your Empire Blue Cross Blue Shield Certificate.

Empire Blue Cross Blue Shield

EMPIRE HEALTHCHOICE ASSURANCE, Inc.
(Effective November 8, 2002)
doing business as
EMPIRE BLUE CROSS BLUE SHIELD
(Effective February 5, 2003)
CERTIFICATE OF INSURANCE
HOSPITAL AND RELATED EXPENSES COVERAGE

Substitute the following for the first sentence of "6" in the "Introduction" section on page 48 of your Empire Blue Cross Blue Shield Certificate.

Empire HealthChoice Assurance

Empire HealthChoice Assurance, Inc., doing business as Empire Blue Cross Blue Shield, is an insurance company organized under the laws of New York State and is a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Substitute the following for the second paragraph of "5. Physical therapy" in the "Outpatient Hospital Care" section on page 52 of your Empire Blue Cross Blue Shield Certificate as amended in your December 2001 Empire Plan Report.

Physical therapy

Effective January 1, 2003. You pay a $10 copayment for each visit to the outpatient department of a hospital for physical therapy when covered by Empire Blue Cross Blue Shield.

Substitute the following for "8. Mammography" in the "Outpatient Hospital Care" section on page 52 of your Empire Blue Cross Blue Shield Certificate.

Mammography

8. **Mammography – Effective January 1, 2003.** Coverage is available under these conditions:

   A. Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer, or who have a first degree relative with a prior history of breast cancer;

   B. A single baseline mammogram for covered persons aged 35 through 39, inclusive;

   C. An annual mammogram for covered persons aged 40 and older, or more frequently upon the recommendation of a physician.

Add the following at the end of the "Outpatient Hospital Care" section on page 52 of your Empire Blue Cross Blue Shield Certificate.

Bone mineral density measurements or tests

10. **Bone mineral density measurements or tests** – Bone mineral density measurements or tests include those measurements or tests covered under the Federal Medicare Program as well as those in accordance with the criteria of the National Institutes of Health, including dual-energy X-ray absorptiometry.

    Empire Blue Cross Blue Shield will pay for bone mineral density measurements or tests when delivered in the outpatient department of a

hospital, if you meet the criteria of New York State Insurance Law, the Federal Medicare Program criteria or the National Institutes of Health criteria, and, at a minimum, meet the following conditions:

A. You have been previously diagnosed as having osteoporosis or you have a family history of osteoporosis; *or*

B. You have symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; *or*

C. You are on a prescribed drug regimen that poses a significant risk of osteoporosis; *or*

D. You have life style factors that pose a significant risk of osteoporosis; *or*

E. You have age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

Add the following after the "Centers of Excellence for Transplants Program" section on page 55 of your Empire Blue Cross Blue Shield Certificate.

Infertility Benefits
Effective January 1, 2003

Infertility benefits

For the purposes of this benefit, infertility is defined as a condition of an individual who is unable to achieve a pregnancy because the individual and/or partner has been diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but has been unable to carry a fetus to full term.

Infertility benefits, including Qualified Procedures (see below), are subject to the same copayments and deductibles as benefits for other medical conditions under the hospital program. Qualified Procedures are subject to a $25,000 lifetime maximum.

What is covered

Covered Services and Supplies include but are not limited to:

- Artificial/intra-uterine insemination
- Inpatient and/or outpatient surgical or medical procedures, performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility or enhance reproductive capability.
- Services in relation to diagnostic tests and procedures necessary:

  (1) to determine infertility; or

  (2) in connection with any surgical or medical procedures to diagnose or treat infertility.

The covered diagnostic tests and procedures include: Hysterosalpingogram; Hysteroscopy; Endometrial Biopsy; Laparoscopy; Sono-Hysterogram; Post-Coital Tests; Testis Biopsy; Semen Analysis; Blood Tests; Ultrasound; and other Medically Necessary Diagnostic Tests and Procedures, unless excluded by law.

Empire Blue Cross Blue Shield will not exclude coverage for medically necessary care for the diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.

Additional Infertility Benefits - Additional Infertility Benefits, called Qualified Procedures (specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility), may be available under the United HealthCare Certificate portion of the Empire Plan.

You must call United HealthCare at 1-877-7-NYSHIP (1-877-769-7447) for prior authorization for Qualified Procedures.

Certain procedures, called Qualified Procedures, obtained in the inpatient or outpatient departments of a hospital, are covered under the Empire Blue Cross Blue Shield portion of this Certificate only if you call United HealthCare

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Book/Certificate continued from page 156

in advance at 1-877-769-7447 and receive prior authorization. If United HealthCare authorizes the Qualified Procedures, the following are covered:

- Assisted Reproductive Technology (ART) procedures including:
  - In vitro fertilization and embryo placement
  - Gamete Intra-Fallopian Transfer (GIFT)
  - Zygote Intra-Fallopian Transfer (ZIFT)
  - Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility
  - Assisted hatching
  - Microsurgical sperm aspiration and extraction procedures, including:
    - Microsurgical Epididymal Sperm Aspiration (MESA), and
    - Testicular Sperm Extraction (TESE)
- Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (that is, freezing and storage of sperm, eggs or embryos).

Maximum lifetime benefit

Benefits paid for Qualified Procedures under the Empire Plan are subject to a lifetime maximum of $25,000 per covered individual. This maximum applies to all covered hospital, medical, travel, lodging and meal expenses that are associated with Qualified Procedures.

Infertility: Exclusions and limitations

Charges for the following expenses are not covered or payable:

- Experimental infertility procedures. (Infertility procedures performed must be accepted as non-experimental by the American Society of Reproductive Medicine.)
- Fertility drugs prescribed in conjunction with Assisted Reproductive Technology and dispensed by a retail pharmacy are not covered under this benefit. **Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under the Empire Plan.**
- Medical expenses or other charges related to genetic selection
- Medical expenses or any other charges in connection with surrogacy
- Any donor compensation or fees charged in facilitating a pregnancy
- Any charges for services provided to a donor in facilitating a pregnancy
- Assisted Reproductive Technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant
- Psychological evaluations and counseling. **See the GHI/ValueOptions Certificate for coverage that may be provided for psychological evaluations and counseling.**

Other exclusions and limitations that apply to this benefit are included under Exclusions in the General Provisions section of this Certificate.

Effective January 1, 2003. *Delete "15. Infertility Services." in the "...General Provisions, Limitations and Exclusions" section on pages 58-59 of your Empire Blue Cross Blue Shield Certificate.*

Substitute the following for the first two sentences of the second paragraph in the "Right to New Contract After Termination" section on page 63 of your Empire Blue Cross Blue Shield Certificate as amended in your June 2002 Empire Plan Report.

New Contract

You may apply to Empire Blue Cross Blue Shield for a direct-payment contract. Direct-payment hospital only coverage and basic medical coverage contracts are available to all enrollees.

UNITED HEALTHCARE CERTIFICATE OF INSURANCE

$10 copayment

Substitute $10 copayment for $8 copayment wherever the $8 appears in your United HealthCare Certificate.

Substitute the following for the last paragraph of "T. 2.b." under "Meaning of Terms Used" on page 75 of your United HealthCare Certificate.

Coinsurance maximum

The $776 coinsurance maximum expense shall be reduced to $500 for calendar year 2003 for employees earning $24,657 or less in full-time base annual salary as of April 1, 2002, provided the employee is the head of household and sole wage earner in the family and applies through the agency Health Benefits Administrator to the Department of Civil Service for this reduction.

Substitute the following for "Z. Your Copayment" under "Meaning of Terms Used" on page 75 of your United HealthCare Certificate.

Copayment

Z. **Effective January 1, 2003.** Your **Copayment** is the first $10 which you are required to pay for certain services by participating providers and MPN Network Providers, or the first $15 in a participating ambulatory surgical center.

Substitute the following for the first paragraph of "A. Office and Home Visits" under "What is covered..." in the "Participating Provider Program" section on page 76 of your United HealthCare Certificate.

Office and home visits

A. **Office and Home Visits –** You are covered for doctor's office visits and home visits by a doctor for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-child care. General medical care includes routine and preventive pediatric care and routine and preventive adult care, including gynecologic exams. The cost of oral and injectable substances for routine preventive pediatric immunizations is covered. Some immunizations for adults also are covered. **Effective February 1, 2003.** The cost of contraceptive drugs and devices that require injection, insertion or other physician intervention is covered when the drugs/devices are dispensed in a doctor's office, subject to a $10 copayment.

Substitute the following for "F. Routine Mammograms" under "What is covered..." in the "Participating Provider Program" section on page 77 of your United HealthCare Certificate.

Routine mammograms

G. **Routine Mammograms.** In addition to mammograms performed when a medical condition is suspected or known to exist, you are covered for mammograms performed as part of routine preventive care under these conditions:

- upon the recommendation of a physician, a mammogram for covered persons at any age having a prior history of breast cancer, or who have a first degree relative with a prior history of breast cancer;
- a single baseline mammogram for covered persons 35 through 39 years of age;
- a mammogram every year for covered persons 40 years of age and older, or more frequently upon the recommendation of a physician.

Add the following at the end of "What is covered..." in the "Participating Provider Program" section on page 78 of your United HealthCare Certificate.

Contraceptive drugs and devices

S. **Contraceptive Drugs and Devices – Effective February 1, 2003.** You pay a $10 copayment for contraceptive drugs and devices when dispensed in a doctor's office.

Substitute the following for the first paragraph of "1. Annual Deductible" in the "Basic Medical Program" section on page 79 of your United HealthCare Certificate.

Annual deductible

For calendar year 2003, the Basic Medical annual deductible for medical services by non-participating providers is $185 for the enrollee, $185 for the enrolled spouse/domestic partner, and $185 for all dependent children combined.

Substitute the following for "D. Nurse Midwife Services" under "What is covered..." in the "Basic Medical Program" section on page 80 of your United HealthCare Certificate.

Maternity care

D. **Maternity Care –** You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, and for complications of pregnancy. United HealthCare's payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided. Maternity care may be rendered by a doctor or by a licensed or certified nurse midwife. The nurse midwife must be:

a. licensed or certified to practice nurse midwifery; and

b. permitted to perform the service under the laws of the state where the services are rendered.

Substitute the following for the first sentence of "U. Miscellaneous Services" under "What is covered..." in the "Basic Medical Program" section on page 81 of your United HealthCare Certificate.

Services and supplies

U. **Miscellaneous Services and supplies –** The following services and supplies are covered under the Basic Medical Program when not covered elsewhere by the Plan:

Add the following to the end of "Miscellaneous Services and Supplies" on page 81 of your United HealthCare Certificate.

i. **Effective February 1, 2003.** Contraceptive drugs and devices that require injection, insertion or other physician intervention when the drugs/devices are dispensed in a doctor's office.

Add the following at the end of "What is covered..." in the "Basic Medical Program" section on page 81 of your United HealthCare Certificate.

Modified solid food products

X. **Modified Solid Food Products – Effective July 15, 2002.** When prescribed by a physician, modified solid food products (MSFP) are covered up to a total maximum reimbursement of $2,500 per covered person per calendar year. *This benefit is not subject to deductible or coinsurance.*

A modified solid food product is a product/food that is low in protein or contains modified protein and is consumed by individuals with certain diseases of amino acid and organic acid metabolism.

Gynecologic exams

Y. **Gynecologic Exams - Effective January 1, 2003.** You are covered for no fewer than two gynecologic exams each year as well as any services resulting from such exams.

Add the following at the end of "You must call..." in the "Home Care Advocacy Program" section on page 84 of your United HealthCare Certificate.

Enteral formulas

5. **Enteral Formulas – Effective July 15, 2002.** You are covered for enteral formulas under HCAP. The enteral formula must be prescribed by your physician and medically necessary as determined by United HealthCare's HCAP. The prescribed enteral formula must be considered safe and effective for the diagnosis.

Enteral formulas are nutritional replacements taken by mouth or through a feeding tube. These formulas provide basic nutrition intended to be used when food in its usual form is not appropriate or adequate to meet the individual's nutritional needs.

Substitute the following for "Network benefits" and "Copayments" in the "Managed Physical Medicine Program" section on page 86 of your United HealthCare Certificate.

Managed Physical Medicine Program

Effective January 1, 2003. You pay a $10 copayment for each office visit for chiropractic treatment or physical therapy when you choose an MPN network provider. You pay an additional $10 copayment for related radiology and diagnostic laboratory services billed by the MPN network provider. If an MPN network provider bills for radiology and diagnostic laboratory services performed during a single office visit, only one copayment for both radiology and diagnostic laboratory services will apply.

$10 copayments when you use a network provider

Substitute the following for "What is covered" in the "Infertility Benefits" section on page 88 of your United HealthCare Certificate.

Infertility benefits

Effective January 1, 2003. Covered Services and Supplies include but are not limited to: Patient Education/Program Orientation; Diagnostic Testing; Ovulation Induction/Hormonal Therapy; Artificial/Intra-Uterine Insemination; and Surgery to enhance reproductive capability.

United HealthCare will not exclude coverage for medically necessary care for the diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.

Effective January 1, 2003. *Delete "Artificial insemination" from the bulleted list of Qualified Procedures in the "Infertility Benefits" section on page 88 of your United HealthCare Certificate and from "Infertility Benefits" under "Important Telephone Numbers" on the inside back cover of your Empire Plan Certificate.*

Substitute the following for the third bullet under "...Qualified Procedures" in the "Infertility Benefits" section on page 88 of your United HealthCare Certificate.

- Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (that is, freezing and storage of sperm, eggs or embryos).

Delete the seventh bullet, "Storage of sperm, eggs or embryos for more than 6 months," under "Infertility: Exclusions and Limitations" in the "Infertility Centers of Excellence" section on page 89 of your United HealthCare Certificate.

GHI CERTIFICATE OF INSURANCE

Empire Plan Mental Health and Substance Abuse Program

Substitute the following for "b" under "Network Coverage" on page 114 of your Mental Health and Substance Abuse Certificate.

Outpatient substance abuse rehabilitation

b. **Effective January 1, 2003.** You pay the first $10 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.

CIGNA CERTIFICATE OF INSURANCE

Empire Plan Prescription Drug Program

Substitute the following for the first paragraph of "Copayments" in the "Your Benefits and Responsibilities" section on page 129 of your CIGNA Certificate.

Copayments: $5 generic/ $15 brand-name

Effective January 1, 2003. Your copayment for up to a 90-day supply is $5 for generic drugs and $15 for brand-name drugs with no generic equivalent. For brand-name drugs with a generic equivalent, you pay a $15 copayment plus the difference in cost between the brand-name drug and its generic equivalent. This cost difference can be substantial.

Substitute the following for the second and third paragraphs of "Mandatory Generic Substitution" in the "Your Benefits and Responsibilities" section on page 130 of your CIGNA Certificate.

Mandatory Generic Substitution

For example, when you use your card at a participating pharmacy, if your prescription is written for:

- **A brand-name drug with a generic equivalent** – You will pay a $15 copayment *plus* the difference in cost between the brand-name and generic drug, not to exceed the full cost of the drug. This cost difference can be substantial.

  The following brand-name drugs are excluded from Mandatory Generic Substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Slo-Bid, Synthroid, Tegretol, and Theo-Dur. You pay only the $15 copayment.
- **A brand-name drug with no generic equivalent** – You pay only the $15 copayment.
- **A generic drug** – You pay only the $5 copayment.

Remember, if your doctor insists on prescribing a brand-name drug that has a generic equivalent, you will pay your $15 copayment plus the difference in cost between the brand-name and generic drug.

Substitute the following for the last paragraph of "Mandatory Generic Substitution" in the "Your Benefits and Responsibilities" section on page 130 of your CIGNA Certificate.

If your appeal is granted, you can fill your prescription for the brand-name drug at an Empire Plan/Express Scripts participating pharmacy or through the mail service pharmacy and pay only the $15 copayment. If your appeal is denied, you can make a second appeal to be reviewed by CIGNA, the program insurer.

Substitute the following for "E." under "What is covered" in the "Your Benefits and Responsibilities" section on page 131 of your CIGNA Certificate.

Contraceptives

E. **Effective February 1, 2003.** Oral, injectable, or surgically implanted contraceptives, which are Federal Legend Drugs, and diaphragms and contraceptive devices.

Substitute the following for "G." under "Exclusions and Limitations" in the "Your Benefits and Responsibilities" section on page 132 of your CIGNA Certificate.

G. **Effective February 1, 2003.** Contraceptive jellies, ointments and foams or devices not requiring a physician's order, prescribed for any reason.

2003 Empire Plan Copayments for Employees of New York State Represented by CSEA

Services by Empire Plan Participating Providers

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

Office Visit.....$10

Office Surgery.....$10

(If there are both an Office Visit charge and an Office Surgery charge by a Participating Provider in a single visit, only one copayment will apply, in addition to any copayment due for Radiology/Laboratory Tests.)

Radiology, Single or Series;
Diagnostic Laboratory Tests $10

(If Outpatient Radiology and Outpatient Diagnostic Laboratory Tests are charged by a Participating Provider during a single visit, only one copayment will apply, in addition to any copayment due for Office Visit/Office Surgery.)

Mammography, according to guidelines $10

Adult Immunizations $10

Allergen Immunotherapy .....No Copay

Well-Child Office Visit, including
Routine Pediatric Immunizations .....No Copay

Prenatal Visits and Six-Week
Check-Up after Delivery.....No Copay

Chemotherapy, Radiation Therapy,
Dialysis .....No Copay

Authorized care at
Infertility Center of Excellence .....No Copay

Hospital-based Cardiac
Rehabilitation Center.....No Copay

Free-standing Cardiac
Rehabilitation Center visit $10

Urgent Care Center $10

Contraceptive Drugs and Devices when
dispensed in a doctor's office.....$10
(in addition to any copayment(s) due for Office Visit/Office Surgery and Radiology/Laboratory Tests)

Ambulatory Surgical Center (including
Anesthesiology and same-day
pre-operative testing done at the center).....$15

Medically appropriate local professional/commercial
ambulance transportation.....$35

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

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

Office Visit.....$10

Radiology; Diagnostic Laboratory Tests.....$10

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

Hospital Outpatient Department Services

Emergency Care.....$35*

(The $35 hospital outpatient copayment covers use of the facility for **E**mergency Room Care, including services of the attending emergency room physician *and* providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.)

Surgery $25*

Diagnostic Laboratory Tests $25*

Diagnostic Radiology (including
mammography, according
to guidelines) $25*

Administration of Desferal for
Cooley's Anemia $25*

Physical Therapy (following related surgery
or hospitalization).....$10

Chemotherapy,
Radiation Therapy, Dialysis .....No Copay

Pre-Admission Testing/Pre-Surgical
Testing prior to inpatient admission .....No Copay

*Only one copayment per visit will apply for all covered hospital outpatient services rendered during that visit. The copayment covers the outpatient facility. Provider services may be billed separately. You will not have to pay the facility copayment if you are treated in the outpatient department of a hospital and it becomes necessary for the hospital to admit you, at that time, as an inpatient.

Be sure to follow **Benefits Management Program** requirements for hospital admissions, skilled nursing facility admission and Magnetic Resonance Imaging.

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

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

Visit to Outpatient Substance Abuse
Treatment Program $10

Visit to Mental Health Professional $15

Psychiatric Second Opinion
when Pre-Certified .....No Copay

Mental Health Crisis Intervention
(three visits).....No Copay

Inpatient.....No Copay

Empire Plan Prescription Drugs

(**Only one** copayment applies for up to a 90-day supply.)

Generic Drug.....$5

Brand-Name Drug
with no generic equivalent.....$15

Brand-Name Drug with a generic
equivalent (with some exceptions) .....$15 *plus* difference in cost between brand-name drug and its generic equivalent