

JANUARY 1, 2014 AMENDMENTS

NYSHIP General Information Book and Empire Plan Certificate Amendments

Police Benevolent Association-Supervisors

For New York State Police Supervisors represented by the **Police Benevolent Association (PBA-S)**, their enrolled Dependents, COBRA Enrollees with their benefits and Young Adult Option Enrollees

Keep these amendments with your 2014 General Information Book and your September 1, 2003 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 Department of Civil Service
Employee Benefits Division
<https://www.cs.ny.gov/employee-benefits>



NYSHIP
New York State
Health Insurance Program

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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.

Your 2014 *NYSHIP General Information Book*, the September 1, 2003 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports and Amendments*, including this publication, collectively constitute your Plan documents. Where this document amends prior Plan documents, this is the controlling document.

Amendments to Plan Documents

The following changes apply throughout the Plan documents:

Disregard the General Information Book portion of your September 1, 2003 “NYSHIP General Information Book and Empire Plan Certificate.” Refer to the new 2014 General Information Book.

Substitute “the Empire Plan Hospital Program administrator” for “Empire BlueCross BlueShield” wherever it appears throughout the Empire Plan Hospital Program Certificate.

Substitute “the Empire Plan Medical/Surgical Program administrator” for “UnitedHealthcare” wherever it appears throughout the Empire Plan Medical/Surgical Program Certificate.

Substitute “the Empire Plan Mental Health and Substance Abuse Program administrator” for “OptumHealth” wherever it appears throughout the Empire Plan Mental Health and Substance Abuse Program Certificate.

Substitute “the Empire Plan Prescription Drug Program administrator” for “UnitedHealthcare” and “Express Scripts/Medco” throughout the Empire Plan Prescription Drug Program Certificate.

Substitute the term “program administrator” for “carrier” and “insurer” wherever they appear throughout the Empire Plan Certificate.

Remove all addresses and phone numbers for program administrators throughout The Empire Plan Certificate and refer instead to the “Contact Information” section on page 378 of this document.

Empire Plan Hospital Program

The following amendments apply to Plan documents for the Empire Plan Hospital Program.

Network and Non-Network Benefits

Substitute the following for item 2 in the “Network and Non-Network Benefits” section on page 309 of your January 2013 “NYSHIP General Information Book and Empire Plan Certificate Amendments,” which amended your 2003 Empire Plan Hospital Program Certificate:

2. Non-network benefits: When you use a non-network hospital, skilled nursing facility or hospice care facility, you are responsible for a larger share of the cost of Covered Services, unless the criteria listed in section C apply. You are responsible for:
 - A. 10 percent of the covered billed charges for inpatient hospital, skilled nursing facility or hospice care facility services up to the combined annual coinsurance maximum;
 - B. 10 percent of the covered billed charges or a \$75 copayment for hospital outpatient services, whichever is greater, up to the combined annual coinsurance maximum; and
 - C. Any penalty amounts that apply as the result of your failure to follow the requirements of the Benefits Management Program.

The covered percentage becomes 100 percent of the covered billed charges for inpatient services only once the combined annual coinsurance maximum is met.

Effective January 1, 2014, the combined annual coinsurance maximum is \$939 for the enrollee, \$939 for the enrolled spouse/domestic partner and \$939 for all dependent children combined.

The combined annual coinsurance maximum will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I.) for Urban Wage Earners and Clerical Workers, all Cities, (C.P.I.-W) for the period July 1 through June 30 of the preceding year. Deductibles do not count toward the combined annual coinsurance maximum.

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

Centers of Excellence

Substitute the following for the last two sentences of the “Centers of Excellence Travel Allowance” section on page 59 of your 2003 Empire Plan Hospital Program Certificate, as amended in your January 2011 “NYSHIP General Information Book and Empire Plan Certificate Amendments”:

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

Empire Plan Medical/Surgical Program

The following amendments apply to Plan documents for the Empire Plan Medical/Surgical Program.

Meaning of Terms Used

Substitute the following for their previous definitions under “Meaning of Terms Used” on page 76 of your Empire Plan Medical/Surgical Program Certificate in your 2003 “NYSHIP General Information Book and Empire Plan Certificate”:

Throughout this Certificate, the meaning of these terms is limited to these definitions:

- C. **Provider** means a practitioner licensed and/or certified and qualified under his/her respective scope of license under applicable state law to perform a covered medical service. Providers include, but are not limited to, Audiologists, Certified Midwives, Chiropractors, Dentists, Nurses, Optometrists, Pathologists, Physical Therapists, Physicians or Speech Therapists. Provider also means facilities legally licensed to perform a covered medical service, including but not limited to Dialysis Centers, Laboratories and Outpatient Surgical Centers.
- D. **Hospital** is defined in the Hospital Program section of this book.
- N. **Medically Necessary or Medical Necessity** means the health care services, supplies and Pharmaceutical Products that are determined by the Medical/Surgical Program administrator to be medically appropriate and:
 - 1. Necessary to meet your basic health needs
 - 2. Rendered in the least intensive and most appropriate setting for the delivery of the service or supply
 - 3. Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies that are accepted by the Medical/Surgical Program administrator
 - 4. Consistent with the diagnosis of the condition
 - 5. Required for reasons other than the comfort or convenience of you or your physician or other provider
 - 6. Demonstrated through prevailing peer-reviewed medical literature to be either:
 - a. safe and effective for treating or diagnosing the sickness or condition for which their use is proposed, or,
 - b. safe with promising efficacy
 - i. for treating life-threatening sickness or condition,
 - ii. in a clinically-controlled research setting, and
 - iii. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

The fact that a physician or other provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this Certificate relates only to coverage and differs from the way in which a physician or other provider engaged in the practice of medicine may define medically necessary.

- O. **Covered Medical Expenses** means the covered charges for covered medical services performed or supplies prescribed by a physician or other provider, except as otherwise provided below, due to your sickness, injury or pregnancy. A covered medical expense is incurred on the date the service or supply is received by you. In order for a charge to be a covered medical expense, the service or supply must be provided by a provider as defined in paragraph C above.

Charges for a service or supply by a person or facility that is not a provider as defined above are not covered medical expenses.

The fact that a physician or other provider recommends that a service be provided by a person who is not a provider does not make the charge for that service a covered medical expense, even if the care provided is medically necessary. These services or supplies must be medically necessary as defined in this section. *A more detailed description of covered expenses and exclusions follows.*

Covered medical expenses are subject to the Medical/Surgical Program's reimbursement policy guidelines. The Medical/Surgical Program administrator develops these reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association and/or the Centers for Medicare and Medicaid Services (CMS)
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Medical/Surgical Program administrator accepts

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the reimbursement policies are applied to provider billings. The Medical/Surgical Program administrator shares the reimbursement policies with participating providers through its provider web site. Participating providers may not bill you for the difference between their schedule of allowances (as may be modified by the reimbursement policies) and the billed charge. However, nonparticipating providers are not subject to this prohibition and they may bill you for any amounts the Medical/Surgical Program administrator does not pay, including amounts that are denied because one of the reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of the reimbursement policies for yourself or to share with your nonparticipating provider by going to the web site listed on the *Contact Information* page for the Medical/Surgical Program or by calling *Customer Care* at the telephone number on your ID card.

- P. **Reasonable and Customary Charge** means the lowest of:
- a. the actual charge for a service or supply; or
 - b. the usual charge by the physician or other provider for the same or similar service or supply; or
 - c. the usual charge of other physicians or other providers in the same or similar geographic area for the same or similar service or supply.

The determination of the reasonable and customary charge for a service or supply is made by the Medical/Surgical Program administrator. In making the determination of the reasonable and customary charge for a service or supply, the Medical/Surgical Program administrator uses data sources including the benchmarking database maintained by FAIR Health, a nonprofit organization approved by the State of New York.

You are responsible for any amount billed by a nonparticipating provider that exceeds the reasonable and customary charge, in addition to the annual deductible and coinsurance amounts.

- Q. **Combined annual deductible** means the amount you must pay in total, each calendar year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program expenses and/or non-network Mental Health and Substance Abuse Program expenses before benefits will be paid under these components of the Plan.

Effective January 1, 2014, The Empire Plan combined annual deductible is \$426 for the enrollee, \$426 for the enrolled spouse/domestic partner and \$426 for all dependent children combined.

The combined annual deductible will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I.) for Urban Wage Earners and Clerical Workers, all Cities, (C.P.I.-W) for the period July 1 through June 30 of the preceding year.

There is a separate deductible of \$250 for the enrollee, \$250 for the enrolled spouse/domestic partner and \$250 for all dependent children combined for non-network physical medicine office visits under the Managed Physical Medicine Program.

- U. **Outpatient** means that covered medical expenses are incurred in a physician's or other provider's office, in the outpatient department of a hospital or in a hospital extension clinic (an outpatient facility that is hospital owned and is not in the same location as the hospital).
- AE. **Pharmaceutical Products** means FDA-approved prescription Pharmaceutical Products administered by a physician or other provider within the scope of the provider's license. Pharmaceutical Products do not include pharmaceuticals that are dispensed to you by a licensed pharmacy, which are subject to the provisions of your prescription drug program.

Substitute the following for item T. 2. b. "Covered Percentage" under "Meaning of Terms Used" on page 78 of your Empire Plan Medical/Surgical Program Certificate in your 2003 "NYSHIP General Information Book and Empire Plan Certificate":

- b. The covered percentage becomes 100 percent of the reasonable and customary charge or the Scheduled Pharmaceutical Amount once the combined annual coinsurance maximum is met.

Effective January 1, 2014, the combined annual coinsurance maximum is \$939 for enrollee, \$939 for the enrolled spouse/domestic partner and \$939 for all dependent children combined.

The combined annual coinsurance maximum will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I.) for Urban Wage Earners and Clerical Workers, all Cities, (C.P.I.-W) for the period of July 1 through June 30 of the preceding year. Deductibles do not count toward the combined annual coinsurance maximum.

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

The 20 percent coinsurance you pay for yourself, your enrolled spouse/domestic partner and for all dependent children combined for covered services by nonparticipating providers count toward your coinsurance maximum. Expenses under the Home Care Advocacy Program, Managed Physical Medicine Program and the Benefits Management Program do not count toward the coinsurance maximum, nor do any penalties under the Benefits Management Program or the Home Care Advocacy Program.

Once the coinsurance maximum is met, covered medical expenses will be reimbursed at 100 percent of the reasonable and customary or Scheduled Pharmaceutical Amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the reasonable and customary or Scheduled Pharmaceutical Amount and any penalties under the benefits management programs.

Participating Provider Program

Add the following after the first sentence of the “Participating Provider Program” section on page 80 of your Medical/Surgical Program Certificate in your 2003 “Empire Plan General Information Book and Empire Plan Certificate”:

When you use a participating provider, you pay only applicable copayments. Not all services are subject to copayments and you pay a maximum of two copayments per visit for services billed by the same provider:

- One copayment applies to charges for an office visit and/or office surgery.
- One copayment applies to charges for laboratory and/or radiology services provided in the same visit. If a laboratory test and/or radiology test is sent to an outside service, an *additional* copayment(s) will apply.

Except as noted below, your copayment is \$20. After you pay any applicable copayments, charges for these services will be paid directly to the participating provider in accordance with the Program’s schedule of allowances.

Substitute the following for the “What is covered under the Participating Provider Program” section on page 80 of your Empire Plan Medical/Surgical Program Certificate in your 2003 “NYSHIP General Information Book and Empire Plan Certificate”:

What is covered under the Participating Provider Program

Under the Participating Provider Program, covered medical expenses include charges for the following services.

- Adult Immunizations** – Immunizations for influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chicken pox), tetanus and meningitis are covered. Immunization for Human Papillomavirus (HPV) is covered for enrollees and dependents age 19 through 26 for females and ages 19-21 for males. Immunization for Herpes Zoster (Shingles) is covered for enrollees and dependents age 55 or older. Covered adult immunizations are subject to an office visit copayment.
- Cardiac Rehabilitation Center** – If your physician prescribes cardiac rehabilitation, you pay a \$20 copayment for each visit to a freestanding cardiac rehabilitation center that has an Empire Plan agreement in effect with the Medical/Surgical Program on the date of your visit. You pay a single copayment for the use of the facility and services you receive from nurses and physicians who monitor the program. There is no copayment for visits to a hospital-based cardiac rehabilitation center that has an Empire Plan agreement in effect with the Medical/Surgical Program administrator on the date of your visit.
- Chronic Care** – You are covered for chronic care services for chemotherapy, radiation therapy and dialysis. There is no copayment for these chronic care services or for related services rendered during the course of chemotherapy, radiation therapy or dialysis.
- Contraceptive Drugs and Devices** – You pay a \$20 copayment for contraceptive drugs and devices when dispensed in a provider’s office (in addition to any copayment(s) due for office visit/office surgery and radiology/laboratory tests).
- Dental Care** – You are covered for dental services, subject to copayment, including Pharmaceutical Products and appliances dispensed by a provider:
 - For the correction of damage caused by an accident, provided the services, supplies or Pharmaceutical Products are received within 12 months of the trauma and while you are covered under this Plan.
 - For the correction of damage caused by a medical illness, congenital disease or anomaly for which you are eligible for benefits under this Plan.
 - For charges incurred for temporomandibular joint (TMJ) syndrome for the following conditions that are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by X-ray: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections and traumatic injuries.

- For TMJ, covered services, supplies or Pharmaceutical Products include diagnostic exams, X-rays, models and testing, injections of medications and trigger point injections.
- F. **Diabetes Education Centers** – If you have a diagnosis of diabetes, you are covered for visits for self-management education, subject to an office visit copayment.
- G. **Diagnostic Laboratory and Radiology** – You are covered for diagnostic laboratory and radiology procedures performed as outpatient services. You are also covered for the separate interpretation of radiology procedures by a radiologist if the radiologist bills separately.
- If both outpatient diagnostic laboratory tests and outpatient radiology procedures are billed by a participating provider during a single visit, only one copayment will apply.
- H. **Infertility Treatment** – See *Infertility Benefits* for information regarding benefits for the treatment of infertility.
- I. **In-Hospital Anesthesia** – You are covered for anesthesia services if such services are performed in connection with in-hospital surgery or maternity care. You are **not** covered if the anesthesia services are administered by your surgeon, by your surgeon’s assistant or by a hospital employee.
- J. **In-Hospital Physician’s or Other Provider’s Visits** – You are covered for physician’s or other provider’s visits while an inpatient in a hospital if such visits are not related to surgery. Benefits for visits related to surgery are included in the scheduled amount for the surgery.
- Services provided in the Outpatient Department of a Hospital** – There is no copayment for covered outpatient services provided in the outpatient department of a hospital by a participating provider.
- K. **Mammograms** – In addition to mammograms performed when a medical condition is suspected or known to exist, you are covered for mammograms under these conditions:
- a single baseline mammogram for covered persons 35 through 39 years of age, subject to copayment;
 - a mammogram every year for covered persons 40 years of age and older, or more frequently upon the recommendation of a physician or other provider. Mammograms performed for routine preventive care are not subject to copayment;
 - upon the recommendation of a physician or other provider, 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 copayment will apply if the covered person is age 39 or younger.
- L. **Mastectomy Bras** – Mastectomy bras, including replacements when functionally necessary, are covered when prescribed by a physician. There is no copayment when you use a participating provider.
- M. **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. The Medical/Surgical Program administrator’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 physician or other provider such as a licensed or certified midwife. The midwife must be:
1. licensed or certified to practice midwifery; and
 2. permitted to perform the service under the laws of the state where the services are rendered.
- There is no copayment for prenatal visits, delivery and the six-week check-up after delivery.

- N. **Nutritional Counseling/Medical Nutritional Therapy** – You are covered when the treatment is medically necessary and the provider is licensed in the state where the service is rendered.
- O. **Office and Home Visits** – You are covered for office visits and home visits by a physician or other provider 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.
- If your participating physician or other provider uses a nonparticipating provider for laboratory testing or interpretation of radiology, that service is covered under Basic Medical Program benefits, subject to deductible and coinsurance.
- There is no copayment for well-child office visits, including routine pediatric examinations, pediatric immunizations, and the cost of oral and injectable substances, according to prevailing clinical guidelines.
- There is no copayment for professional services for allergy immunotherapy or allergy serum when billed by a participating provider. If there is an associated office visit, a copayment will apply.
- P. **Outpatient Surgical Location** – You pay a \$30 copayment for facility charges at a freestanding outpatient surgical location that has an Empire Plan agreement in effect with the Medical/Surgical Program on the date of your elective surgery. You pay a single copayment for anesthesiology, radiology and laboratory tests performed at the outpatient surgical location on the same day as the surgery. You pay an additional \$30 copayment for pre-operative testing performed on a different day from the surgery. Surgeons' charges are billed separately and covered under either the Participating Provider or Basic Medical Program provisions.
- Q. **Pediatric immunizations** – Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and the cost of oral and injectable substances when administered according to pediatric immunization guidelines.
- R. **Podiatry** – You are covered for the services of a podiatrist **except** for routine care of the feet, subject to copayment.
- S. **Prostheses and Orthotic Devices** – You are covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs. There is no copayment for the prosthesis and/or orthotic device when you use a participating provider. Replacements, when functionally necessary, are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot is covered only when it is medically necessary and custom made.
- T. **Reconstructive Surgery** – You are covered, subject to copayment, for the services of a physician or other provider for the following:
- Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:
 - Birth defect
 - Sickness
 - Accidental injury
 - Reconstructive breast surgery following a medically necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following the mastectomy).
 - Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other medically necessary surgery.
- U. **Second Opinion for Cancer Diagnosis** – You pay a \$20 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

- V. **Specialist Consultations** – A consultation is more extensive than an office visit. A physician may refer you to a specialist for consultation to have your medical condition evaluated and to obtain professional advice regarding how to proceed with your care.
- You are covered, subject to copayment(s), for **one out-of-hospital** consultation in each specialty field per calendar year for each condition being treated. You are covered for **one in-hospital** consultation in each specialty field, per confinement, for each condition being treated.
- You are **not** covered for consultations in the fields of pathology, roentgenology, or anesthesiology. Exception: consultations by an anesthesiologist, not rendered in conjunction with anesthesia services for surgery, such as office consultations for pain management, are covered when medically necessary.
- W. **Speech Therapy** – You are covered, subject to copayment, for the services of a speech therapist or speech-language pathologist when:
1. such services are prescribed and supervised by your physician;
 2. treatment is medically necessary; and
 3. the provider is currently licensed in the state where the service is rendered.
- X. **Surgery** – You are covered for the services of a physician or other provider for surgery, including post-operative care, whether performed in or out of a hospital, subject to the appropriate copayment.
- Y. **Urgent Care Center** – Services received at an Urgent Care Center that has an Empire Plan agreement in effect with the Medical/Surgical Program on the date of your visit are covered, subject to copayment.

Basic Medical Program

Substitute the following for the first two paragraphs of “Annual Deductible” on page 83 of your Empire Plan Medical/Surgical Program Certificate in your 2003 “NYSHIP General Information Book and Empire Plan Certificate”:

Effective January 1, 2014, The Empire Plan combined annual deductible is \$426 for the enrollee, \$426 for the enrolled spouse/domestic partner and \$426 for all dependent children combined.

The combined annual deductible will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I.) for Urban Wage Earners and Clerical Workers, all Cities, (C.P.I.-W) for the period July 1 through June 30 of the preceding year.

You must meet the combined annual deductible before your Basic Medical claims can be reimbursed.

Substitute the following sections on page 83 of your Empire Plan Medical/Surgical Program Certificate in your 2003 “NYSHIP General Information Book and Empire Plan Certificate”:

B. Coverage

The Medical/Surgical Program administrator will pay **Basic Medical benefits** to the extent covered medical expenses in a calendar year **exceed the deductible and coinsurance, up to the reasonable and customary charge or the Scheduled Pharmaceutical Amount.**

C. Covered Basic Medical Expenses

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

Covered medical expenses under the Basic Medical Program are also subject to the definition of covered medical expenses as stated under the “Meaning of Terms Used” in this Certificate.

Substitute the following for “What is covered under the Basic Medical Program (nonparticipating providers)” on page 83 of your Empire Plan Medical/Surgical Program Certificate in your 2003 “NYSHIP General Information Book and Empire Plan Certificate”:

What is covered under the Basic Medical Program (nonparticipating providers)

Under the Basic Medical Program, covered medical expenses include charges for the following services or supplies:

- A. **Ambulance Service** – Emergency 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 ambulance transportation is required because of an emergency condition. Medically necessary non-emergency transportation is covered if provided by a licensed ambulance service.

Covered medical expenses for ambulance services include the following:

1. Local commercial ambulance charges except for the first \$35. *These amounts are not subject to deductible or coinsurance.*
 2. When the enrollee has no obligation to pay, donations up to a maximum of \$50 for trips of fewer than 50 miles and up to \$75 for trips over 50 miles will be reimbursed for voluntary ambulance services. *These amounts are not subject to deductible or coinsurance.*
- B. **Anesthesiology, Radiology and Pathology** – If you receive anesthesia, radiology or pathology services in connection with covered inpatient or outpatient hospital services at an Empire Plan network hospital and The Empire Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by the Medical/Surgical Program.
- C. **Cardiac Rehabilitation Center** – Medically necessary visits to a cardiac rehabilitation center are covered when prescribed by a physician.
- D. **Dental Care** – You are covered for dental services, including Pharmaceutical Products and appliances dispensed by a provider:
- For the correction of damage caused by an accident, provided the services, supplies or Pharmaceutical Products are received within 12 months of the trauma and while you are covered under this Plan.
 - For the correction of damage caused by a medical illness, congenital disease or anomaly for which you are eligible for benefits under this Plan.
 - For charges incurred for temporomandibular joint (TMJ) syndrome for the following conditions that are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by X-ray: degenerative arthritis, osteoarthritis, ankylosis, tumors, infections and traumatic injuries.
 - For TMJ, covered services, supplies or Pharmaceutical Products include diagnostic exams, X-rays, models and testing, injections of medications and trigger point injections.
- E. **Diabetes Education Centers** – If you have a diagnosis of diabetes, you are covered for medically necessary visits for self-management, subject to deductible and coinsurance.
- F. **Eye Care Following Cataract Surgery** – The charges for one pair of prescription eyeglasses or contact lenses and one eye examination are covered medical expenses per affected eye per cataract surgery.
- G. **Gynecologic Exams** – You are covered for a minimum of two gynecologic exams each year as well as any services resulting from such exams.

H. **Hearing Aids** – Hearing aids, including evaluation, fitting and purchase, are covered up to a total maximum reimbursement of \$1,500 per hearing aid per ear, once every four years. Children age 12 years and under are eligible to receive a benefit of up to \$1,500 per hearing aid per ear, once every two years when it is demonstrated that a covered child’s hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child’s hearing loss. *These benefits are not subject to deductible or coinsurance.*

I. **Hospital Emergency Room** – If the Hospital Program administrator determines that you received emergency care in a hospital emergency room, covered charges billed separately by the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electro-cardiograms and/or pathology services, will be paid in full by the Medical/Surgical Program.

Services provided by other specialty physicians or other providers in a hospital emergency room are considered under the Participating Provider Program if the physician participates in The Empire Plan.

If the Emergency Services are provided by a nonparticipating provider, the charges will be considered under the Basic Medical Program, subject to deductible but not coinsurance.

J. **Hospitals** – Charges for room and board and special services provided to you as an inpatient are covered after Hospital Program benefits have been exhausted.

Remember: You must comply with the requirements of the hospital and Benefits Management Program for a hospital admission. Refer to the details of how this program works in the *Benefits Management Program* section of this book.

If and when it is determined that inpatient care is no longer medically necessary, benefits will cease and notice will be given to the hospital and patient the day before your benefits end.

The Medical/Surgical Program will provide coverage for services and supplies in connection with Infertility Benefits and Cancer Resource Services whether or not benefits are available under The Empire Plan’s hospital benefits plan.

K. **Infertility Treatment** – See *Infertility Benefits* for information regarding benefits for the treatment of infertility.

L. **Mammograms :**

Part of Routine Preventive Care – You are covered for preventive care mammograms according to the same guidelines that apply under the Participating Provider Program.

New York State law also provides for an annual mammogram for covered females age 40 and older.

Part of a Medical Condition – Mammograms are covered when a medical condition is suspected or known to exist; this benefit is subject to deductible and coinsurance.

M. **Mastectomy Bras** – When prescribed by a physician or other provider, mastectomy bras, including replacements when functionally necessary, are covered, subject to deductible and coinsurance.

N. **Mastectomy Protheses** – One single or double mastectomy prosthesis per calendar year is covered in full. Any single external mastectomy prosthesis costing \$1,000 or more requires prior approval through the Home Care Advocacy Program (HCAP). For a prosthesis requiring approval, if a less expensive prosthesis can meet an individual’s functional needs, benefits will be available for the most cost-effective choice. *This benefit is not subject to deductible or coinsurance.*

O. **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. The Medical/Surgical Program administrator’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 physician or other provider such as a licensed or certified midwife. The midwife must be:

1. licensed or certified to practice midwifery; and
2. permitted to perform the service under the laws of the state where the services are rendered.

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

1. Diagnostic laboratory procedures and radiology
2. X-ray or radiation treatments
3. Oxygen and its administration
4. Anesthetics and their administration, except when performed by your physician or other provider
5. Blood transfusions, including the cost of blood and blood products; however, such costs will be covered medical expenses only to the extent that there is evidence, satisfactory to the Medical/Surgical Program, that such supplies could not be obtained without cost
6. Chemotherapy
7. Dialysis
8. Speech therapy
9. Contraceptive drugs and devices that require injection, insertion or other provider intervention when the drugs/devices are dispensed in a provider's office
10. Adult immunizations provided at non-network pharmacies

Q. **Modified Solid Food Products** – When prescribed by a physician or other provider, 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.

R. **Nutritional Counseling/Medical Nutritional Therapy** – You are covered when the treatment is medically necessary and the provider is licensed in the state where the service is rendered.

S. **Outpatient Surgical Location** – You are covered for medically necessary facility charges at a freestanding outpatient surgical location.

T. **Physicians** – Services of physicians and other providers who perform covered medical services are covered.

U. **Podiatrists** – Services of duly licensed podiatrists for the treatment of (i) diseases, (ii) injuries and (iii) malformation of the foot are covered, except that those treatments or supplies listed in Items P and Q of the Exclusions segment are not covered medical expenses. See *General Provisions: Exclusions*.

V. **Prosthesis and Orthotic Devices** – One prosthesis and/or orthopedic appliance commonly known as an orthotic device, per affected body part meeting an individual's functional needs, is covered.

Replacements, when functionally necessary, are also covered. However, an orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot is covered under the Basic Medical Program only when it is medically necessary and custom made.

W. **Prosthetic wigs** are covered up to the \$1,500 lifetime benefit maximum when hair loss is long term and due to a medical condition. These conditions include: disease of the endocrine glands,

generalized systemic disease, systemic poisons and hair loss due to radiation therapy, chemotherapy treatment or injury to the scalp. *This benefit is not subject to deductible or coinsurance.*

Prosthetic wigs are **not** covered when hair loss is due to male or female pattern baldness.

- X. **Reconstructive Surgery** – You are covered for reconstructive surgery under the same conditions as the Participating Provider Program.
- Y. **Routine Health Exams for Active Employees** – Routine health exams are covered for you, the active employee, if you are age 50 or older and for your spouse/domestic partner age 50 or older. *These benefits are not subject to deductible or coinsurance.*
- Z. **Routine Newborn Child Care** – Physician’s or other provider’s services for routine care of a newborn child are covered. *These benefits are not subject to deductible or coinsurance.*
- AA. **Routine Pediatric Care** – Routine well-child care is covered for children up to age 19, including examinations, immunizations and the cost of oral and injectable substances, according to pediatric care guidelines.
- AB. **Second Opinion for Cancer Diagnosis** – Charges for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer are covered in full, minus the \$20 copayment you would normally pay for a visit to a participating provider. *This benefit is not subject to deductible.*
- AC. **Specialist Consultations** – Charges for a consultation with a specialist who is a nonparticipating provider are considered under the Basic Medical Program and are subject to your annual deductible and coinsurance.

Basic Medical Benefits are available for **one out-of-hospital** consultation in each specialty field per calendar year for each condition being treated. Basic Medical benefits are available for one **in-hospital** consultation in each specialty field, per confinement, for each condition being treated.

You are **not** covered for consultations in the fields of pathology, roentgenology, or anesthesiology. Exception: Consultations by an anesthesiologist not rendered in conjunction with anesthesia services for surgery, such as office consultation for pain management, are covered when medically necessary.

- AD. **Surgery** – You are covered for the services of a physician or other provider for surgery, including post-operative care, under the Basic Medical Program when not covered elsewhere by the Plan.

Multiple surgical procedures performed during the same operative session may be subject to a reduction in reimbursement. Multiple surgical procedures shall be reimbursed in an amount not less than the reasonable and customary charge for the most expensive procedure performed. Less expensive procedures shall be reimbursed in an amount at least equal to 50 percent of the reasonable and customary charge for these secondary procedures.

When you use a participating provider, you are responsible only for any applicable copayment(s).

- AE. **Urgent Care Center** – You are covered for medically necessary visits to and services provided at an urgent care center, subject to copayment.
- AF. **Voluntary Sterilization** – Charges for voluntary sterilization are covered medical expenses.

Home Care Advocacy Program (HCAP)

Substitute the following for the third and fourth paragraphs in “Non-network benefits” under “Non-network coverage: If you do not call or if you call HCAP but do not use an HCAP provider” on page 90 of your Empire Plan Medical/Surgical Program Certificate in your 2003 “NYSHIP General Information Book and Empire Plan Certificate”:

The combined annual deductible applies: Effective January 1, 2014, The Empire Plan combined annual deductible is \$426 for the enrollee, \$426 for the enrolled spouse/domestic partner and \$426 for all dependent children combined.

The combined annual deductible will increase on January 1 of each year based on the percentage increase in the medical care component of the Consumer Price Index (C.P.I.) for Urban Wage Earners and Clerical Workers, all Cities, (C.P.I.-W) for the period July 1 through June 30 of the preceding year.

You must satisfy the combined annual deductible before non-network benefits will be paid for HCAP-covered services, equipment or supplies. The amount applied toward satisfaction of the combined annual deductible for non-network HCAP-covered services, equipment and supplies will be the lower of the following:

- The amount you actually paid for a medically necessary service, equipment or supplies covered under HCAP; or
- The network allowance for such service, equipment or supply.

Non-network Benefits: After you have satisfied the combined annual deductible, submit a claim to the Medical/Surgical Program administrator. You will be reimbursed for medically necessary HCAP-covered home care services, durable medical equipment or supplies up to a maximum of 50 percent of the network allowance. You are responsible for any amounts in excess of 50 percent of the network allowance. The combined annual coinsurance maximum does not apply to HCAP.

Centers of Excellence

Substitute the following for the last two sentences of the “Centers of Excellence Travel Allowance” section on page 94 of your 2003 Empire Plan Medical/Surgical Program Certificate, as amended in your January 2011 “NYSHIP General Information Book and Empire Plan Certificate Amendments”:

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

The Travel Allowance will be applied toward the \$50,000 maximum lifetime benefit for Infertility Benefits.

Empire Plan Mental Health and Substance Abuse Program

The following amendments apply to Plan documents for the Empire Plan Mental Health and Substance Abuse Program.

Conversion to Self-Insured

Delete the Certificate of Insurance signature page on page 326 of your Empire Plan Mental Health and Substance Abuse Program Certificate in your January 2013 "NYSHIP General Information Book and Empire Plan Certificate Amendments." **Note:** Effective January 1, 2014, the Empire Plan Mental Health and Substance Abuse Program was converted from fully insured to self-insured under a self-insured administrative services agreement between the New York State Department of Civil Service (DCS) and ValueOptions.

How to Receive Benefits for Mental Health and Substance Abuse Care

Replace the first sentence of the second paragraph under "Non-Network Coverage" on page 333 of your Empire Plan Mental Health and Substance Abuse Program Certificate in your January 2013 "NYSHIP General Information Book and Empire Plan Certificate Amendments" with the following: For a non-emergency admission to a non-network facility (including residential treatment facilities, halfway houses and group homes), you must call the Empire Plan Mental Health and Substance Abuse Program administrator before the admission to have the medical necessity of the admission certified.

What is Covered Under the Mental Health and Substance Abuse Program

Delete the last two sentences under part "B. Residential Treatment Facilities, Halfway Houses and Group Homes" in the "What is Covered Under the Mental Health and Substance Abuse Program" section on page 334 of your Empire Plan Mental Health and Substance Abuse Program Certificate in your January 2013 "NYSHIP General Information Book and Empire Plan Certificate Amendments."

Non-Network Coverage for Mental Health and Substance Abuse Care

Substitute the following for the fourth and fifth paragraphs under "You are Responsible for Obtaining OptumHealth Certification for Care Obtained from a Non-Network Provider" section on page 339 of your Empire Plan Mental Health and Substance Abuse Program Certificate in your January 2013 "NYSHIP General Information Book and Empire Plan Certificate Amendments":

The Empire Plan **combined annual deductible** is \$426 for the enrollee, \$426 for the enrolled spouse/domestic partner and \$426 for all dependent children combined. The combined annual deductible must be met before your claims can be reimbursed.

The Empire Plan **combined annual coinsurance maximum** is \$939 for the enrollee, \$939 for the spouse/domestic partner and \$939 for all dependent children combined.

Substitute the following as the last paragraph under "Maximums" on page 339 of your Empire Plan Mental Health and Substance Abuse Program Certificate in your January 2013 "NYSHIP General Information Book and Empire Plan Certificate Amendments":

Effective January 1, 2014, Applied Behavior Analysis was limited to 680 hours each plan year. **Effective January 1, 2015**, there is no annual maximum for Applied Behavior Analysis services, network and non-network combined.

Empire Plan Prescription Drug Program

The following amendments apply to Plan documents for the Empire Plan Prescription Drug Program.

Conversion to Self-Insured

Delete the Certificate of Insurance signature page on page 238 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments.” **Note:** Effective January 1, 2014, the Empire Plan Prescription Drug Program was converted from fully insured to self-insured under a self-insured administrative services agreement between the New York State Department of Civil Service (DCS) and CVS/caremark.

Meaning of Terms Used

Replace the definition for “Excluded Drug” on page 240 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments” with the following:

- I. **Excluded Drug:** A drug that is excluded from coverage under this Program’s benefit plan design. This Program will provide no benefit for an excluded drug and you will be responsible for paying the total retail cost of the drug. See “N. Medical Exception Process” for information on how to appeal an excluded drug.

Replace the definition for “Grace Fill for Specialty Drugs” on page 352 of your January 2013 “NYSHIP General Information Book and Empire Plan Certificate Amendments,” which amends your 2009 Empire Plan Prescription Drug Program Certificate, with the following:

- M. **Grace Fill for Specialty Drugs** means that an enrollee is allowed to have the First Fill of certain Specialty Drugs/Medications dispensed from a Pharmacy other than the Designated Specialty Pharmacy. Specialty Drugs/Medications identified as being for short-term therapy for which a delay in starting therapy would not affect clinical outcome do not have a Grace Fill.

Add the following definition on page 241 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments” and re-number all remaining definitions:

- N. **Medical Exception Process:** A process by which a physician can request a medical necessity review for non-formulary prescription drugs that are excluded from coverage. An appropriate trial of formulary alternatives must be undertaken before a medical exception can be requested.

Copayments

Add the following note to the end of the “Copayments” section on page 242 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments”:

Note: Oral chemotherapy drugs, when prescribed for the treatment of cancer, do not require a copayment.

Supply and Coverage Limits

Substitute the following for the “Supply and Coverage Limits” section on page 242 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments”:

Certain drugs may be subject to quantity-level limits based on clinical and safety factors related to the dispensing of medication. Additional clinical quantity-level limits are based on criteria developed by the Prescription Drug Program administrator. The number of days’ supply for controlled drugs is in accordance with federal and State mandates.

Erectile dysfunction drugs are limited to a specific quantity-per-day supply: 6 units for a 30-day supply and 7 to 18 units for a 31- to 90-day supply.

Specialty drugs/medications may be dispensed for up to a 90-day supply when clinically appropriate. Certain specialty drugs/medications may only be dispensed for up to a 30-day supply due to clinical/dispensing guidelines.

For certain drugs that have quantity-level limits, additional quantities may be covered through prior authorization. These drugs will be noted with QL/PA on the formulary. Please see the “Prior Authorization” section of this Certificate for information on how to request a prior authorization.

Empire Plan Flexible Formulary

Add the following at the end of the “Empire Plan Flexible Formulary” section on page 243 of your 2009 Empire Plan Prescription Drug Program Certificate, as amended in your January 2010 “NYSHIP General Information Book and Empire Plan Certificate Amendments”:

Please refer to the “Miscellaneous Provisions” section of the Certificate for information regarding the medical exception process for drugs that are excluded from the Flexible Formulary.

Prior authorization required for certain drugs

Substitute the following list in the “Prior authorization required for certain drugs” section on page 353 of your January 2013 “NYSHIP General Information Book and Empire Plan Certificate Amendments,” which amended your 2009 Empire Plan Prescription Drug Program Certificate:

The following is a list of drugs (including generic equivalents) that require prior authorization:

- Abstral
- Actemra
- Actiq
- Adcirca
- Adempas (effective 4/1/14)
- Ampyra
- Aranesp
- Aubagio
- Avonex
- Bivigam (effective 7/1/14)
- Botox
- Cayston
- Cimzia
- Copaxone
- Dysport
- Egrifta
- Enbrel
- Epogen/Procrit
- Extavia
- Fabior (effective 7/1/14)
- Fentora
- Flolan
- Forteo
- Gattex (effective 7/1/14)
- Gilenya
- Growth Hormones
- Humira
- Immune Globulins
- Incivek
- Increlex
- Infergen (effective 4/1/14)
- Intron A
- Kalydeco
- Kineret
- Korlym
- Kuvan
- Lamisil
- Lazanda
- Letairis
- Makena
- modafanil
- Myobloc
- Nuvigil
- Olysio (effective 4/1/14)
- Onmel
- Onsolis
- Opsumit
- Orenicia
- Orenitram (effective 7/1/14)
- Otezla (effective 7/1/14)
- Otrexup (effective 7/1/14)
- Pegasys
- PegIntron
- Rebif
- Remicade
- Remodulin
- Revatio
- Simponi
- Sovaldi (effective 4/1/14)
- Sporanox
- Stelara
- Subsys
- Synagis
- Tazorac
- Tecfidera
- Tracleer
- Tysabri
- Tyvaso
- Veletri
- Ventavis
- Victrelis
- Weight Loss Drugs
- Xeljanz
- Xeomin
- Xolair
- Xyrem

Replace the first paragraph following the “Prior authorization required for certain drugs” list on page 244 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information and Empire Plan Certificate Amendments” with the following:

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds \$200 will require Prior Authorization under this Program. This list of drugs is subject to change. For the most current list of drugs requiring prior authorization and to learn how to obtain prior authorization, call

The Empire Plan toll free and choose the Empire Plan Prescription Drug Program or visit our web site (see *Contact Information* at the end of this document).

Specialty Pharmacy Program

Replace the second paragraph under “Specialty Pharmacy Program” on page 292 of your January 2010 “NYSHIP General Information Book and Empire Plan Certificate Amendments,” which amended your 2009 Empire Plan Prescription Drug Program Certificate, with the following:

The Program requires certain Specialty Drugs/Medications to be dispensed by the Designated Specialty Pharmacy. When initiating therapy with a Specialty Drug/Medication, you may send the prescription directly to the Designated Specialty Pharmacy to start receiving specialty program benefits. Otherwise, you are allowed one Grace Fill for Specialty Drugs, during which time, the Program will cover the First Fill of your medication at any Network Pharmacy with the applicable copayment. (Specialty Drugs/Medications identified as being for short-term therapy for which a delay in starting therapy would not affect clinical outcome do not have a Grace Fill.)

What is covered

Replace the explanation for item E under “What is Covered” on page 292 of your January 2010 “NYSHIP General Information Book and Empire Plan Certificate Amendments,” which amended your 2009 Empire Plan Prescription Drug Program Certificate, with the following:

- E. First Fill of a Specialty Drug/Medication filled at a Network, Non-Network or Mail Service Pharmacy and subsequent fills processed by the Designated Specialty Pharmacy. Specialty Drugs/Medications identified as being for short-term therapy for which a delay in starting therapy would not affect clinical outcome do not have a Grace Fill.

Exclusions and Limitations

Substitute the following for item R in the “Exclusions and Limitations” section on page 353 of your January 2013 “NYSHIP General Information Book and Empire Plan Certificate Amendments,” which amended your 2009 Empire Plan Prescription Drug Program Certificate:

- R. Prescription drug products excluded from the benefit plan design, including: Actos, Acuvail, Adderall XR, Adoxa, Advicor, Altoprev, amlodipine-atorvastatin, Amrix, Analpram Advanced Kit, Anrogel, Apexicon E, Apidra, Apidra Solostar, Aplenzin, Aricept 23 mg, Arthrotec, Asacol HD, Atacand, Atacand HCT, Atelvia, Benzefoam, Betaseron, Caduet, Cambia, carisoprodol 250 mg, Centany AT, Clindacin PAC, Clindagel, clobetasol shampoo, Clobex Shampoo, Clobex Spray, Conzip, Coreg CR, cyclobenzaprine ext-rel, Delzicol, Desvenlafaxine ER, Detrol, Detrol LA, Dexilant, Diovan HCT, Doryx, doxycycline hyclate ext-rel tablet, doxycycline monohydrate 150 mg capsule, Duexis, Dymista, Edluar, Epiduo, Exforge, Exforge HCT, Flector, Flo-Pred, Fortamet, Fortesta, Genotropin, Glumetza, hecoria, Humalog, Humalog Mix 50/50, Humalog Mix 75/25, Humulin, Innopran XL, Intermezzo, Jalyn, lansoprazole capsule, Lescol XL, levabuterol inhalation solution, Lipitor, LipTruzet, Lortab Elixir, Lorzone, Metadate CD, Metozolv ODT, Momexin Kit, Morgidox Kit, Naprelan, Nexium*, Noritate, Nutropin, Nutropin AQ, Nutropin AQ Nuspin, Olux-E, omeprazole-sodium bicarbonate capsule, Omnitrope, Oxytrol, Pennsaid, Plavix, Pramoxone E, Prevacid, Prevacid Solutab, Pristiq, Procort, Protonix, Provigil, Relion Insulin, Requip XL, Retin-A Micro, Riomet, Ritalin, Ritalin LA, Ritalin SR, ropinirole ext-rel, Rowasa, Saizen, Sanctura XR, Silenor, Soma 250 mg, Sonata, Suboxone Film, Sumaxin TS, Terbinex, Testim, Teveten, Teveten HCT, Tev-Tropin, Tobradex Ointment, Tobradex ST, Toviaz, tramadol ext-rel (generic RYZOLT only), Treximet, Tribenzor, Tricor, Trilipix, Twynsta, Uramaxin GT, Uramaxin Kit, Valtrex, Veltin, Veramyst, Vimovo, Xerese, Xopenex, Zegerid Capsule, Ziana, Zipsor, Zolpimist, Zolvit, Zomig Nasal Spray, Zuplenz, Zyclara, Zymaxid.

Half Tablet/Pill Splitting Program

Delete the section “Half Tablet/Pill Splitting Program” from page 248 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments.” **Note:** As of December 31, 2013, the Half Tablet/Pill Splitting Program was discontinued and the reduced copayment no longer applies.

Miscellaneous Provisions

Add the following at the end of the “Miscellaneous Provisions” section on page 252 of your Empire Plan Prescription Drug Program Certificate in your January 2009 “NYSHIP General Information Book and Empire Plan Certificate Amendments”:

Medical Exception Process for Drugs Excluded from the Flexible Formulary (for non-Medicare-primary enrollees)

Effective September 1, 2014, The Empire Plan includes a medical exception process for non-formulary prescription drugs that are excluded from coverage. Enrollees and their physicians must first evaluate whether covered drugs on the Flexible Formulary are appropriate alternatives for their treatment. After an appropriate trial of formulary alternatives, an enrollee’s physician may submit a letter of medical necessity to the Empire Plan Prescription Drug Program administrator, which details the enrollee’s formulary alternative trials and any other clinical documentation supporting medical necessity. The physician can fax the exception request (see the *Contact Information* section for details). If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment (and ancillary charge, if applicable) will apply for brand-name drugs.

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

Contact Information

Keep the following contact list with your NYSHIP General Information Book and Empire Plan Certificate. This list replaces all addresses, phone numbers and web sites listed in your NYSHIP General Information Book, your Empire Plan Certificate and any previous Certificate Amendments and Empire Plan Reports.

The Empire Plan

www.cs.ny.gov/employee-benefits

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



Medical/Surgical Program: Administered by UnitedHealthcare

Choose this option for medical/surgical benefits, claims and most appeals; outpatient radiology; certification of home care; medical equipment and supplies; Infertility and Cancer Centers of Excellence or chiropractic or physical therapy benefits; and policy conversions.

Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern Time
TTY: 1-888-697-9054

UnitedHealthcare
P.O. Box 1600
Kingston, NY 12402-1600

External Appeals

To request an application from the New York State Department of Financial Services:
1-800-400-8882

Home Care Advocacy Program (HCAP) Appeals

Home Care Advocacy Program
P.O. Box 5400
Kingston, NY 12402-5400

Diabetic Supplies (except insulin pumps and Medijectors)

Empire Plan Diabetic Supplies Pharmacy
1-888-306-7337

Ostomy Supplies

Byram Healthcare Centers
1-800-354-4054



Hospital Program: Administered by Empire BlueCross BlueShield

(Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.)

Choose this option for hospital benefits and most claims and appeals, preadmission certification of inpatient hospital, skilled nursing facility admissions and Centers of Excellence for Transplant surgeries.

Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern Time
TTY: 1-800-241-6894

Empire BlueCross BlueShield
New York State Service Center
P.O. Box 1407, Church Street Station
New York, NY 10008-1407

Other Claims

If the hospital does not deal directly with its local Blue Cross Plan:

When filing the claim directly with the local Blue Cross Plan, refer the bill to:
Code YLS, Empire BlueCross BlueShield
New York State Service Center
P.O. Box 1407, Church Street Station
New York, NY 10008-1407

Hospitals Outside of the United States:

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126

Written Appeals

New York State Service Center
Medical Management Appeals Department
Mail Drop R 60
P.O. Box 11825
Albany, NY 12211

External Appeals

New York State Department of Financial Services
1-800-400-8882

PRESS OR SAY 3 **Mental Health and Substance Abuse Program: Administered by ValueOptions**
Choose this option for mental health and substance abuse and claims, authorization of services and referrals to network providers.

Representatives are available 24 hours a day, seven days a week.
TTY: 1-855-643-1476

ValueOptions
P.O. Box 1800
Latham, NY 12110

Written Appeals

ValueOptions
Appeals Department
P.O. Box 1800
Latham, NY 12110

External Appeals

New York State Department of Financial Services
1-800-400-8882

PRESS OR SAY 4 **Prescription Drug Program: Administered by CVS/caremark**
Choose this option for prescription drug benefits and claims, Empire Plan Formulary and the Mail Service Pharmacy.

Representatives are available 24 hours a day, seven days a week.
TTY: 1-800-863-5488

General Correspondence, Prior Authorization, Grievances
CVS/caremark
Customer Care Correspondence
P.O. Box 6590
Lee's Summit, MO 64064-6590

Mail Service Pharmacy
CVS/caremark
P.O. Box 2110
Pittsburgh, PA 15230-2110

Claims

Mail completed claim forms to:

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

Medical Exception Requests for Drugs Excluded from the Flexible Formulary
Tell your physician to fax these requests to: 1-888-487-9257

Written Appeals

Prescription Claim Appeals
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

External Appeals

New York State Department of Financial Services
1-800-400-8882

If you are unable to resolve a problem with an Empire Plan program administrator

Contact The Consumer Assistance Unit of the New York State Department of Financial Services at:
New York State Department of Financial Services
One Commerce Plaza, Albany, NY 12257
1-800-342-3736 Monday through Friday 9 a.m. to 5 p.m. Eastern Time

NYSHIP HMOs

NYSHIP HMO contact information, including phone numbers, TTY numbers, addresses and web sites are available in the *Choices* booklet and on the New York State Department of Civil Service web site at <https://www.cs.ny.gov/employee-benefits>.

Medicare Benefits and Claims

Including the Medicare Competitive Bidding Program for durable medical equipment and prosthetic and orthotics supplies.

1-800-MEDICARE (1-800-633-4227)
<http://www.medicare.gov>