AT A GLANCE

JANUARY 2021

EXCELSIOR Participating Agencies

For Employees, Retirees, Vestees and Dependent Survivors enrolled in the Excelsior Plan through Participating Agencies and their enrolled Dependents; and for COBRA enrollees and Young Adult Option Enrollees with their Excelsior Plan benefits

This guide briefly describes Excelsior Plan benefits. For information regarding your New York State Health Insurance Program (NYSHIP) eligibility or enrollment, contact your Health Benefits Administrator. If you have questions regarding specific benefits or claims, contact the appropriate Plan administrator (see page 19).

NEW YORK STATE | The Excelsior Plan

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

WHAT'S NEW

- **Expanded National Network –** Effective January 1, 2021, Plan enrollees and covered dependents will have access to UnitedHealthcare's nationwide network of participating providers. The expanded network includes over 1.2 million physicians, laboratories and other providers such as physical therapists, occupational therapists and chiropractors located throughout the United States.
- **COVID-19 Related Benefits –** To receive up-to-date information about what you need to know to access Plan benefits during the coronavirus pandemic, please visit NYSHIP Online at www.cs.ny.gov/employee-benefits, and click on What's New.
- **Telehealth Coverage –** The Plan covers telehealth visits with participating providers in the Medical/Surgical Program and the Mental Health and Substance Abuse (MHSA) Program. Enrollees and covered dependents can access care through a video visit with their own doctor or therapist on a smartphone, tablet or personal computer. Telehealth visits are subject to the same enrollee cost sharing as in-person visits.
- **Virtual Health Care Access with LiveHealth Online (LHO) –** With Empire BlueCross' partnership with LiveHealth Online, enrollees can stay home and have a telephone or video visit with a board-certified doctor or licensed therapist via smartphone, tablet, or personal computer. To get started, go to www.empireblue.com/nys and select the link to LiveHealth Online. Or, call LHO at 1-888-LiveHealth (1-888-548-3432), 24 hours/day, seven days/week.
- **In-Network Out-of-Pocket Limit –** Each year the Federal Affordable Care Act sets new amounts limiting total network out-of-pocket costs. For 2021, the maximum out-of-pocket limit for covered, in-network services under The Excelsior Plan is $8,550 for Individual coverage and $17,100 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. See page 3 for more information.
- **2021 Excelsior Plan Drug List –** The 2021 Excelsior Plan Drug lists the most commonly prescribed generic and brand name drugs and newly excluded drugs with the 2021 Excelsior Plan Drug List alternatives.

Quick Reference

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

Hospital Program

administered by Empire BlueCross

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

Medical/Surgical Program

administered by UnitedHealthcare

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

Also provides coverage for home care services, durable medical equipment and related medical supplies through the Home Care Advocacy Program; the Prosthetics/Orthotics Network; Center of Excellence Programs for Cancer and for Infertility; and Benefits Management Program services, including Prospective Procedure Review for MRIs, MRAs, CT scans, PET scans, nuclear medicine tests, voluntary specialist consultant evaluation services, outpatient medical case management and the Empire Plan NurseLine℠ for health information and support.

Mental Health & Substance Abuse Program

administered by Beacon Health Options, Inc.

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

Prescription Drug Program

administered by CVS Caremark

Provides coverage for prescription drugs dispensed through Empire Plan network pharmacies, the CVS Mail Service Pharmacy, the CVS Specialty Pharmacy and non-network pharmacies.

See *Contact Information* on page 19.

Benefits Management Program

The Benefits Management Program helps to protect the enrollee and allows the Plan to continue to cover essential treatment for patients by coordinating care and avoiding unnecessary services. The Benefits Management Program precertifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient medical case management. In order to receive maximum benefits under the Plan, you must follow the Benefits Management Program requirements. This includes obtaining precertification for certain services when the Excelsior Plan is your primary coverage (pays first, before another health plan or Medicare).

YOU MUST CALL
for preadmission certification

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

- Before a scheduled (nonemergency) hospital admission, skilled nursing facility admission/transfer or transplant surgery.*
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.*
- For admission resulting from complications due to pregnancy or for any reason other than the delivery of the baby.* It is also recommended that you call if you or your baby are hospitalized for more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery.

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

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

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

- Concurrent review of hospital inpatient treatment
- Discharge planning for medically necessary services post-hospitalization
- Inpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care
- The Future Moms Program for early risk identification and for online breastfeeding support

YOU MUST CALL
for Prospective Procedure Review

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

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computerized tomography (CT) scan
- Positron emission tomography (PET) scan
- Nuclear medicine test

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

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

- Coordination of voluntary specialist consultant evaluation
- Outpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care

Out-Of-Pocket Costs

In-Network Out-of-Pocket Limit

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

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

Beginning January 1, 2021, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,550 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- $3,000 for in-network expenses incurred under the Prescription Drug Program

Family Coverage

- $11,100 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- $6,000 for in-network expenses incurred under the Prescription Drug Program

Out-of-Network Combined Annual Deductible

The combined annual deductible is $1,500 for the enrollee, $1,500 for the enrolled spouse/domestic partner and $1,500 for all dependent children combined.

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

Combined Annual Coinsurance Maximum

The combined annual coinsurance maximum is $4,750 for the enrollee, $4,750 for enrolled spouse/domestic partner, and $4,750 for all dependent children combined.

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

Preventive Care Services

Your Plan benefits include provisions for expanded coverage of preventive health care services required by the federal Patient Protection and Affordable Care Act (PPACA).

When you meet established criteria (such as age, gender and risk factors) for certain preventive care services, those preventive services are provided to you at no cost when you use a Plan participating provider or network facility. See the *2021 Empire Plan Preventive Care Coverage Guide* for examples of covered services.

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

Center of Excellence Programs

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

Cancer Services*

YOU MUST CALL the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program or call the Cancer Resource Services toll free at 1-866-936-6002 and register to participate

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

Transplants Program*

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

Paid-in-full benefits are available for the following transplant services when authorized by the Hospital Program and received at a designated Center of Excellence or a BlueCross BlueShield Association's Blue Distinction Centers for Transplants:

- Pretransplant evaluation of transplant recipient
- Inpatient and outpatient hospital and physician services
- Up to 12 months of follow-up care

You must call the Plan for preauthorization of the following transplants provided through the Center of Excellence for Transplants Program: bone marrow, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell and simultaneous kidney/pancreas. When applicable, a travel allowance is available. If you choose to have your transplant in a facility other than a designated Center of Excellence (or if you require a small bowel or multivisceral transplant) you may still take advantage of the Hospital Program case management services, in which a nurse will help you through the transplant process, if you enroll in the Center of Excellence for Transplants Program. If a transplant is authorized but you do not use a designated Center of Excellence, benefits will be provided in accordance with Hospital and/or Medical/Surgical Program coverage. **Note:** Transplant surgery preauthorization is required whether or not you choose to participate in the Center of Excellence for Transplants Program.

Infertility Benefits*

PRESS OR SAY 1 Call The Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program for predetermination

Paid-in-full benefits are available, subject to the lifetime maximum for Qualified Procedures ($50,000 per covered person) including any applicable travel allowance, when you choose a Center of Excellence for Infertility. To request a list of Qualified Procedures, verify coverage of infertility benefits, or to find out how using a Center of Excellence offers you the highest level of benefits available for infertility care, call the Medical/Surgical Program.

The lifetime maximum applies to all covered hospital, medical, travel, lodging and meal expenses associated with the Qualified Procedure. If three IVF cycles have not been completed once the $50,000 lifetime maximum is reached, the Plan will cover the remaining IVF cycles until three have been met, including the associated travel, lodging and meal expenses.

Center of Excellence Program Travel Allowance

When you are enrolled in the Center of Excellence Program or use a Center of Excellence for preauthorized infertility services, a travel, lodging and meal expenses benefit is available for travel within the United States. The benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, it will include coverage for up to two companions.

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

Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the U.S. General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. Once you arrive at your lodging and need transportation from your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

Hospital Program

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

The Hospital Program pays for covered services provided by a network inpatient or outpatient hospital, skilled nursing facility or hospice setting. There is no coverage for services provided in a non-network facility except in an emergency or if a network facility is not available. The Medical/Surgical Program provides benefits for medical and surgical services, as well as certain hospital services, if not covered by the Hospital Program.

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

Network Coverage

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

Non-Network Coverage

Services provided in a hospital, skilled nursing facility or hospice that is not part of The Empire Plan network are not covered.

Exceptions

Network coverage applies for services received in a non-network facility when you:

- Receive emergency or urgent services in a non-network facility
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence that can provide the service you require

Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Hospital Inpatient

YOU MUST CALL
for preadmission certification (see page 2)

Network Coverage

You pay a $250 copayment per admission. You will pay a maximum of four inpatient copayments per enrollee, per spouse/domestic partner and per all dependent children combined each calendar year.

You are covered for up to a combined maximum of 365 days per spell of illness for covered inpatient diagnostic and therapeutic services or surgical care in a network hospital.

Non-Network Coverage

No coverage in a non-network hospital. Exceptions apply based on access, see above.

Hospital Outpatient

If you are admitted as an inpatient directly from the outpatient department, hospital clinic or emergency department, the hospital outpatient copayment or emergency department copayment is waived and only the hospital inpatient copayment applies.

Emergency Department

Network Coverage

You pay one $130 copayment per visit to an emergency department, including use of the facility for emergency care, services of the attending physician, services of providers who administer or interpret laboratory tests and electrocardiogram services. Other physician charges are covered under the Medical/Surgical Program (see page 7).

The copayment is waived if you are admitted as an inpatient directly from the emergency department, and only the hospital inpatient copayment applies.

Non-Network Coverage

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

Outpatient Department or Hospital Extension Clinic

Network Coverage

Outpatient surgery is subject to a $130 copayment.

You pay one $85 copayment per visit for diagnostic radiology and diagnostic laboratory tests.

You have paid-in-full benefits for:

- Preadmission and/or presurgical testing prior to an inpatient admission
- Chemotherapy
- Radiation therapy
- Anesthesiology
- Pathology
- Dialysis

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

- Bone mineral density tests
- Colonoscopies
- Mammograms*
- Pap smears
- Proctosigmoidoscopy screenings
- Sigmoidoscopy screenings

* *Screening, diagnostic and 3-D mammograms are paid in full under New York State law.*

Medically necessary physical therapy following a related hospitalization or related inpatient surgery is subject to a $35 copayment per visit. Physical therapy must start within six months from your discharge from the hospital or the date of your outpatient surgery and be completed within 365 days from the date of hospital discharge or outpatient surgery.

Non-Network Coverage

No coverage in a non-network hospital. Exceptions apply in certain situations (see page 5).

Skilled Nursing Facility Care

YOU MUST CALL
for preadmission certification (see page 2)

Benefits are subject to the requirements of the Plan's Benefits Management Program if the Excelsior Plan provides your primary health coverage. The Plan does not provide skilled nursing facility benefits, even for short-term rehabilitative care, for retirees, vestees, dependent survivors or their dependents who are eligible for primary benefits from Medicare.

Network Coverage

Covered in an approved network facility when medically necessary in place of hospitalization.

Non-Network Coverage

No coverage in a non-network hospital. Exceptions apply in certain situations (see page 5).

Hospice Care

Network Coverage

Care provided by a licensed hospice program is paid in full. Enrollees are eligible for hospice care if the doctor and hospice medical director certify that the covered patient is terminally ill and likely has less than 12 months to live.

Non-Network Coverage

No coverage for non-network hospice care. Exceptions apply in certain situations (see page 5).

Medical/Surgical Program Benefits for Physician/Provider Services Received in a Hospital Inpatient or Outpatient Setting

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

Participating Provider Program
Covered services are paid in full when the provider participates in The Empire Plan network, except for radiology, anesthesiology or pathology services, which are subject to a $50 copayment.

Basic Medical Program
If you receive covered radiology, anesthesiology or pathology services in connection with covered inpatient or outpatient services at an Empire Plan network hospital and the Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist and pathologist will be paid in full by the Medical/Surgical Program after you pay an initial $50 copayment. Services provided by other nonparticipating providers are subject to deductible and coinsurance.

Emergency care in a hospital emergency department, provided by:

- An attending emergency department physician is paid in full
- Participating or nonparticipating providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams and/or pathology are paid in full
- Other participating providers are paid in full
- Other nonparticipating providers (e.g., surgeons) are considered under the Basic Medical Program and are not subject to deductible and coinsurance

All other services subject to deductible and coinsurance.

The Excelsior Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from nonparticipating (non-network) providers at a network facility without their knowledge. See *Out-of-Network Reimbursement Disclosures* or contact the Medical/Surgical Program for more information.

Medical/Surgical Program

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

The Medical/Surgical Program covers services received from a physician or other practitioner licensed to provide medical/surgical services. The Basic Medical Program also provides coverage for continued hospital inpatient services after hospital inpatient benefits end. Services and supplies must be covered and medically necessary. Call the Medical/Surgical Program if you have questions about coverage, benefits or the status of a provider.

Participating Provider Program

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

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

The Plan provides guaranteed access for primary care physicians and certain medical specialties.

Guaranteed Access

When there are no participating providers within a reasonable distance, access to network benefits will be available to enrollees for primary care physicians and certain core provider specialties. To receive this benefit:

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

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

Primary Care	***Specialist***
Urban: 3 miles	Urban: 10 miles
Suburban: 15 miles	Suburban: 20 miles
Rural: 40 miles	Rural: 40 miles

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

Primary Care Providers	***Specialties***	***Specialties***	***Specialties***
Family practice	Allergy	Neurology	Pulmonary medicine
General practice	Anesthesia	Ophthalmology	Radiology
Internal medicine	Cardiology	Orthopedic surgery	Urology
Pediatrics	Dermatology	Otolaryngology	
Obstetrics/gynecology	Laboratory	Pathology	

Basic Medical Program

The Basic Medical Program provides benefits for services/supplies received from a provider that does not participate in The Empire Plan network and also provides coverage for continued hospital inpatient services, after hospital inpatient benefits end. Your out-of-pocket costs are higher when you use a nonparticipating provider.

Combined annual deductible: The combined annual deductible must be satisfied before the Plan reimburses for benefits received from a nonparticipating provider (see page 3).

Coinsurance: After you meet the combined annual deductible, the Plan reimburses 80 percent of the allowed amount. You are responsible for the balance.

Combined annual coinsurance maximum: After the combined annual coinsurance maximum is reached, benefits are reimbursed at 100 percent of the allowed amount for covered services (see page 3).

Allowed Amount
The allowed amount is:

- 110 percent of the published rates allowed by the Centers for Medicare & Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
- When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology developed by OptumInsight to determine a rate for the service. This methodology uses relative values from the OptumInsight Relative Value Scale, which is usually based on the difficulty, time, work, risk and resources of the service or
- When a rate is not published by CMS and the OptumInsight gap methodology does not apply to the service, the eligible expense is based on 50 percent of the billed charge.

OptumInsight is a wholly-owned subsidiary of UnitedHealth Group and is an affiliate of UnitedHealthcare. The network allowance generally equates to 11 percent of FAIR Health© Usual and Customary professional rates.* FAIR Health© is a nonprofit organization approved by the State of New York as a benchmarking database. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the usual and customary rate for these services in your geographic area or ZIP code.

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

Office Visits

Participating Provider Program

You pay a single $35 copayment per visit for all covered services provided during the visit and billed by the provider. There is no copayment for prenatal visits, well-child care and preventive services as defined by the Patient Protection and Affordable Care Act.

Basic Medical Program

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Routine Health Exams

Participating Provider Program

Preventive routine health exams are paid in full.

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

Basic Medical Program

Routine health exams are covered for active employees age 50 or older, not subject to deductible or coinsurance.

Routine health exams are not covered for dependents (spouse/domestic partner, dependent children), retirees, vestees or dependent survivors.

Covered services, such as laboratory tests and screenings provided during a routine exam that fall outside the scope of a routine exam, are subject to deductible and coinsurance. For further information, contact the Medical/Surgical Program.

Diagnostic Laboratory Services

Participating Provider Program

You pay a single $35 copayment for covered services provided by a participating laboratory.

Basic Medical Program

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Diagnostic and Imaging Services

Participating Provider Program

Imaging procedures subject to Prospective Procedure Review (PPR) are subject to a $80 copayment:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computerized tomography (CT) scan
- Positron emission tomography (PET) scan
- Nuclear medicine test

You pay a single $35 copayment for other diagnostic radiology and imaging services received at a participating free-standing (non-hospital based) facility.

Basic Medical Program

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Note: Interpretation of diagnostic test results billed separately by a different provider are covered separately. You will be subject to copayment or deductible and coinsurance under the Basic Medical Program for that service, depending on the status of the provider.

Adult Immunizations

Participating Provider Program

The following adult immunizations are paid in full, based on recommendations by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:

- Influenza (flu)*
- Pneumococcal (pneumonia)*
- Measles, mumps, rubella (MMR)
- Varicella (chickenpox)
- Tetanus, diphtheria, pertussis (Td/Tdap)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Meningococcal (meningitis)*
- Herpes zoster (shingles)*
  - Shingrix®
    No copayment is required for enrollees age 50 and older.
  - Zostavax®
    No copayment for enrollees age 60 and older; enrollees between the ages of 55 and 59 are subject to a Level 1, 30-day supply copayment at a network pharmacy or a medical copayment at a physician's office.

Doses, recommended ages and populations vary. Other immunizations may be subject to a copayment.

* *Paid in full under the Prescription Drug Program at all CVS Caremark National Vaccine Network Pharmacies, subject to age limitations. The shingles vaccine requires a prescription. See page 17 for vaccinations covered under the Prescription Drug Program.*

Basic Medical Program

Not covered.

Routine Pediatric Care • *Up to age 19*

Participating Provider Program

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

Basic Medical Program

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

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

Outpatient Surgical Locations

Participating Provider Program

A $95 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a participating outpatient surgical center.

Basic Medical Program

Covered services provided by a nonparticipating outpatient surgical center are subject to Basic Medical Program benefits, including deductible and coinsurance.

Hospital and hospital-based outpatient surgical locations are covered under the Hospital Program (see *Outpatient Department or Hospital Extension Clinic*, page 6).

Prostheses and Orthotic Devices

Participating Provider Program

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

Basic Medical Program

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

External Mastectomy Prostheses

Basic Medical Program

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

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

Gender Dysphoria Treatment

Participating Provider and Basic Medical Programs

Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery and other associated surgeries, services, and procedures, including those to change your physical appearance to more closely conform secondary sex characteristics to those of your identified gender, are covered when your behavioral health provider completes a determination of medical necessity.

Emergency Ambulance Service

Basic Medical Program

Local commercial ambulance transportation is a covered basic medical expense subject only to a $70 copayment. Volunteer ambulance transportation will continue to be reimbursed for donations at the current rates of $50 for under 50 miles and $75 for over 50 miles. This benefit applies whether you use an ambulance service that is a participating provider or a nonparticipating provider and is not subject to deductible or coinsurance.

Managed Physical Medicine Program

Administered by Managed Physical Network (MPN)

Chiropractic Treatment, Physical Therapy and Occupational Therapy

Network Coverage

Each office visit to a network provider is subject to a $35 copayment, which includes related radiology and diagnostic laboratory services billed by the network provider.

MPN guarantees access to network benefits. If there are no network providers in your area, you must contact MPN prior to receiving services to arrange for network benefits. Physical therapy must be prescribed by a provider.

Non-Network Coverage

There is no non-network coverage.

Home Care Advocacy Program (HCAP)

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

YOU MUST CALL
for prior authorization

Network Coverage *(when you use HCAP)*

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

Exceptions: For diabetic supplies (except insulin pumps and Medi-Jectors), call the Plan's Diabetic Supplies Pharmacy at 1-800-321-0591. For ostomy supplies, call Byram Healthcare Centers at 1-800-354-4054.

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

The first 48 hours of nursing care are not covered. After you meet the combined annual deductible (see page 3), the Plan pays up to 50 percent of the HCAP network allowance for covered services, durable medical equipment and supplies. This reimbursement generally equates to 43 percent of FAIR Health© Usual and Customary professional rates.* There is no coinsurance maximum.

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

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

Mental Health And Substance Abuse Program

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

To receive the highest level of benefits you must call the Mental Health and Substance Abuse (MHSA) Program before seeking services from a mental health or substance use care provider. This includes treatment for alcoholism and services that require precertification to confirm medical necessity before starting treatment (see list below). Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 3 to reach the Mental Health and Substance Abuse Program. You can reach the Clinical Referral Line by selecting option 3 from the MHSA Program menu. The Clinical Referral Line is available 24 hours a day, every day of the year. In an emergency, go to the nearest hospital emergency department. You or your designee should call the Mental Health and Substance Abuse Program within 48 hours of an admission for emergency care or as soon as reasonably possible. To check if providers or facilities are in The Empire Plan network, visit NYSHIP Online at www.cs.ny.gov/employee-benefits. Choose your group and plan, if prompted, and select Find a Provider. Under the MHSA Program, click on the ReferralConnect link. On ReferralConnect you can search for a specific provider or provider type in your area. If there are no network providers in your area, you have guaranteed access to network level benefits if you call the Clinical Referral Line to arrange your care with an appropriate provider.

Schedule of Benefits for Covered Services

The Program Administrator must certify all covered services as medically necessary, regardless of whether you are using Network or Non-Network coverage. If the Program Administrator does not certify your inpatient or outpatient treatment as medically necessary, you will not receive any Plan benefits and you will be responsible for the full cost of care.

The following services require Precertification from the Program Administrator:

- Intensive outpatient program for mental health
- Structured outpatient program for substance use disorder
- 23-hour bed for mental health or substance use disorder
- 72-hour bed for mental health or substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavioral Analysis (ABA)
- Group home
- Halfway house
- Residential treatment center for mental health*
- Residential treatment center for substance use disorder**
- Partial hospitalization for mental health
- Partial hospitalization for substance use disorder

** Precertification is not required for covered individuals under 18 years of age at OMH-certified network facilities located within New York State.*

*** Precertification is not required for OASAS-certified Network Facilities located within New York State.*

Network Coverage

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

Non-Network Coverage

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

Services provided in a hospital or inpatient facility that is not part of The Empire Plan network are not covered.

Exceptions

Network coverage applies for services received in a non-network facility when you:

- Receive emergency or urgent services in a non-network facility
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence or that can provide the service you require

Call the Mental Health and Substance Abuse Program to determine if you qualify for network coverage at a non-network hospital based on access.

Inpatient Services

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

Network Coverage

You pay a $250 copayment per admission to an approved facility. You will pay a maximum of four inpatient copayments per enrollee, per spouse/domestic partner and per all dependent children combined each calendar year.

Practitioner treatment or consultation: Treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner — not the facility — are paid in full.

Non-Network Coverage

No coverage in a non-network hospital. Exceptions apply in certain situations, see above.

Practitioner treatment or consultation: Treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner — not the facility — are subject to deductible and coinsurance as described under *Office Visits and Other Outpatient Services,* below.

Ambulance Service

Ambulance service to a hospital where you receive mental health care or substance use care treatment is covered when medically necessary, except for the first $70. When the enrollee has no obligation to pay, donations up to $50 for trips of fewer than 50 miles and up to $75 for trips over 50 miles will be reimbursed for voluntary ambulance services. This benefit is not subject to deductible or coinsurance.

Outpatient Services

Hospital Emergency Department

Network Coverage

You pay one $130 copayment per visit to an emergency department. The copayment is waived if you are admitted as an inpatient directly from the emergency department, and only the inpatient copayment applies.

Non-Network Coverage

Network coverage applies to emergency department visits at a non-network hospital.

Office Visits and Other Outpatient Services

Network Coverage

Office visits and other outpatient services, such as outpatient substance use rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a $35 copayment per visit.

Up to three visits per crisis are paid in full for mental health care treatment. After the third visit, the $35 copayment per visit applies.

Allowed Amount
The allowed amount means the lower of billed charges or 110 percent of the Medicare allowance.

Non-Network Coverage

Combined annual deductible: The combined annual deductible must be satisfied before the Plan pays benefits (see page 3).

Coinsurance: After you meet the combined annual deductible, the Plan pays 80 percent of the allowed amount.

Combined annual coinsurance maximum: After the combined annual coinsurance maximum is reached, the plan pays benefits for covered services at 100 percent of the usual and customary rate (see page 3).

Prescription Drug Program

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

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

Copayments

You have the following copayments for covered drugs purchased from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy.

Drug Category	Up to a 30-day Supply from a Network Pharmacy, the Mail Service Pharmacy or the Specialty Pharmacy	31- to 90-day Supply from a Network Pharmacy	31- to 90-day Supply from the Mail Service Pharmacy or the Specialty Pharmacy
Level 1 Drugs	$10	$30	$25
Level 2 Drugs	$45	$100	$100
Level 3 Drugs	$85	$200	$200

Drugs not Subject to Copayment

Certain covered drugs do not require a copayment:

- Oral chemotherapy drugs, when prescribed for the treatment of cancer
- Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices), with up to a 12-month supply of contraceptives at one time without an initial 3-month supply
- Tamoxifen, raloxifene, anastrozole and exemestane when prescribed for women age 35 and over for the primary prevention of breast cancer
- Pre-Exposure Prophylaxis (PrEP), when prescribed for enrollees who are at high risk of acquiring HIV
- Certain preventive adult vaccines when administered by a licensed pharmacist at a pharmacy that participates in the CVS Caremark national vaccine network
- Certain prescription and over-the-counter medications* that are recommended for preventive services without cost sharing and have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF)

** When available over-the-counter, USPSTF "A" and "B" rated medications require a prescription order to process without cost sharing.*

Mandatory Generic Substitution

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

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

Exceptions

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

Excelsior Plan Drug List

The Excelsior Plan Drug List is a managed formulary that may exclude certain drugs in a therapeutic category. The drug list may be subject to change quarterly. For the current drug list, go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then 2021 Excelsior Plan Drug List. Or, call the Prescription Drug Program and request an updated printed copy of the Excelsior Plan Drug List.

Prior Authorization Drugs

You must have prior authorization for certain drugs, including generic equivalents.

Certain medications also require prior authorization based on age, gender or quantity limit specifications. Compound drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization. **The drugs that require prior authorization are subject to change as drugs are approved by the U.S. Food and Drug Administration (FDA), introduced into the market or approved for additional indications.** For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then 2021 Drugs that Require Prior Authorization.

Excluded Drugs

Certain brand-name and generic drugs are excluded from the Excelsior Plan Drug List if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2021 Excelsior Plan Drug List includes drugs that are excluded in 2021, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. For a complete list of Excluded Drugs, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then 2021 Excluded Drug List. Also check the website for current information regarding exclusions of newly launched prescription drugs.

Medical Exception Program for Excluded Drugs

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

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

If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment 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.

Types of Pharmacies

Network Pharmacy

A network pharmacy is a retail pharmacy that participates in the CVS Caremark network. When you visit a network pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail network pharmacy location that participates in the CVS Caremark network, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, and select Find a Provider.

CVS Caremark National Vaccine Network Pharmacy

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

- Influenza (flu)
- Pneumococcal (pneumonia)
- Meningococcal (meningitis)
- Herpes zoster (shingles)* — *requires prescription*

To find out if a pharmacy participates in the CVS Caremark national vaccine network, call the Prescription Drug Program or visit www.empireplanrxprogram.com and select CVS Caremark, then Find a Local Pharmacy. Be sure to select Vaccine network under Advanced Search. Only certain pharmacies are part of the CVS Caremark national vaccine network. Call the pharmacy in advance to verify availability of the vaccine.

** Shingrix® is covered for individuals 50 and older at no copayment. Zostavax® is covered with no copayment for individuals 60 and older and at a Level 1, 30-day supply copayment for ages 55 to 59.*

Mail Service Pharmacy

You may request that your prescriber send your prescription to the CVS Caremark Mail Service Pharmacy. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone or online at www.empireplanrxprogram.com or download forms on NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted. Select Forms and scroll down to the CVS Caremark Mail Service Order Form.

Specialty Pharmacy Program

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

- Refill reminder calls
- Expedited, scheduled delivery of your medications at no additional charge
- All necessary supplies, such as needles and syringes applicable to the medication at no additional cost
- Disease education
- Drug education
- Compliance management
- Side-effect management
- Safety management

Prior authorization is required for some specialty medications. To get started with the CVS Caremark Specialty Pharmacy, to request refills or to speak to a specialty-trained pharmacist or nurse, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) Monday through Friday between 7:30 a.m. and 9 p.m. Eastern time. Choose the Prescription Drug Program, and ask to speak with Specialty Customer Care. If your call is urgent, you may request an on-call pharmacist 24 hours a day, seven days a week.

A complete list of specialty medications included in the Specialty Pharmacy Program is available on NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then Specialty Pharmacy Drug List.

Non-Network Pharmacy

If you do not use a network pharmacy, or if you do not use your Excelsior Plan benefit card at a network pharmacy, you must submit a claim for reimbursement to: The Empire Plan Prescription Drug Program, c/o CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136.

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

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

Benefits On The Web

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

- Current publications describing your benefits and plan
- Announcements
- An event calendar
- Prescription drug information
- Contact information
- Links to all program administrator websites

To find the most up-to-date information about your health insurance coverage, go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, to get to the NYSHIP Online homepage. You can bookmark this page to bypass the login screen the next time you sign in.

Contact Information

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

PRESS OR SAY 1	**Medical/Surgical Program: *Administered by UnitedHealthcare*** Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time. TTY: 1-888-697-9054 P.O. Box 1600, Kingston, NY 12402-1600 Claims submission fax: 845-336-7716 Online submission: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Empire BlueCross*** Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans. Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern time. TTY: 1-800-241-6894 New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 Claims submission fax: 888-367-9788 Online form: www.empireblue.com/forms/
PRESS OR SAY 3	**Mental Health and Substance Abuse Program: *Administered by Beacon Health Options, Inc.*** Representatives are available 24 hours a day, seven days a week. TTY: 1-855-643-1476 P.O. Box 1850, Hicksville, NY 11802 Claims submission fax: 855-378-8309 Online form: www.achievesolutions.net/achievesolutions/en/empireplan/Home.do
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS Caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 711 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590
PRESS OR SAY 5	**Empire Plan NurseLine℠: *Administered by UnitedHealthcare*** Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.

This document provides a brief look at the Excelsior Plan benefits for enrollees of Participating Agencies. If you have questions, call *1-877-7-NYSHIP (1-877-769-7447)* and choose the program you need.

NEW YORK STATE | **NYSHIP** New York State Health Insurance Program

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

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

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

New York State
Department of Civil Service
Employee Benefits Division
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NEW YORK STATE | **NYSHIP**
New York State
Health Insurance Program

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

Excelsior Plan At A Glance — January 2021

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

It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on NYSHIP Online at www.cs.ny.gov/employee-benefits. Visit NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS agency websites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator (HBA). COBRA Enrollees: Contact your former HBA.

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The Excelsior Plan Copayments at a Glance

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

Medical/Surgical Program	$35 copayment – Office visit, telehealth visit, office surgery, radiology, diagnostic laboratory tests, freestanding cardiac rehabilitation center visit, convenience care clinic visit $40 copayment – Non-hospital urgent care center visit $70 copayment – Licensed Ambulance Service $80 copayment – Prospective Procedure Review for MRIs, MRAs, CT scans, PET scans and nuclear medicine tests $95 copayment – Non-hospital outpatient surgical locations **Chiropractic treatment or physical therapy services (Managed Physical Medicine Program)** $35 copayment – Office visit, radiology, diagnostic laboratory tests
Hospital Program	$35 copayment – Outpatient physical therapy $85 copayment – Outpatient services for diagnostic radiology and diagnostic laboratory tests, urgent care center visit $130 copayment – Emergency department visit, outpatient surgery $250 copayment – Inpatient hospital stay
Mental Health and Substance Abuse Program	$35 copayment – Visit to an outpatient substance use treatment program $35 copayment – In-person or telehealth visit to a mental health professional $130 copayment – Emergency department visit $250 copayment – Inpatient hospital stay
Prescription Drug Program	Up to a 90-day supply from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy (see copayment chart on page 15).