

## ARTICLE 12- HEALTH INSURANCE

1. Effective March 31, 2005 the Hospital Emergency Room copayment will increase to \$50.
2. Effective March 31, 2005 the Hospital Outpatient copayment will increase to \$35. Coincident with the increase in the hospital outpatient copayment, services provided in a hospital owned or operated extension clinic will be paid by the hospital carrier.
3. Effective March 31, 2005 no payment will be made for inpatient hospital days determined to be non-medically necessary by the hospital carrier.
4. Effective March 31, 2005 the Hospital component (inpatient and outpatient services) of the Empire Plan will be modified as follows:
  - The Hospital carrier will establish a network of hospitals (acute care general hospitals, skilled nursing facilities and hospices) throughout the United States.
  - Any hospital that does not enter into a participating agreement with the hospital carrier will be considered to be a non-network facility.
  - Covered inpatient services received at a network hospital will be paid-in-full. Covered outpatient services (outpatient lab, x-ray, etc. and emergency room) received at a network hospital will be subject to the appropriate copayment.
  - Covered inpatient services received at a non-network hospital will be reimbursed at 90% of charges. There will be a separate \$1500 annual Hospital coinsurance maximum per enrollee, enrolled spouse/domestic partner and all dependent children combined established for non-network hospital out-of-pocket expenses.
  - The \$1500 Hospital coinsurance maximum is for non-network hospital expenses only and cannot be combined with any coinsurance maximums for other Empire Plan components.
  - Covered outpatient services received at a non-network hospital will be reimbursed at 90% of charges. The enrollee will be responsible for 10% of charges(coinsurance) or a \$75 copayment whichever is

greater. The non-network outpatient coinsurance/copayment will be applied toward the \$1500 annual coinsurance maximum.

- Once the enrollee, enrolled spouse/domestic partner or all dependent children combined have incurred \$500 in non-network expenses, a claim may be filed with the medical carrier for reimbursement of out-of-pocket non-network expenses incurred above the \$500 and up to the balance of the coinsurance maximum.
  - Services received at a non-network hospital will be reimbursed at the network level of benefits under the following situations:
    - Emergency outpatient/inpatient treatment;
    - Inpatient/outpatient treatment only offered by a non-network hospital;
    - Inpatient/outpatient treatment received outside of the US; and
    - Inpatient/outpatient treatment in geographic areas where reasonable access to a network hospital does not exist.
  - Anesthesiology, pathology and radiology services received at a network hospital will be paid-in-full even if the provider is not participating in the Empire Plan participating provider network under the medical component.
5. Effective March 31, 2005 the participating provider office visit, office surgery, radiology and laboratory copayments will increase to \$15.
6. Effective March 31, 2005 the Empire Plan Prescription Drug Program will be modified as follows:
- i. A third tier of prescription drugs and prescription drug copayment will be created to differentiate between preferred and non-preferred brand-name drugs.
  - ii. The copayment will be \$5 for generic drugs, \$15 for preferred brand name drugs and \$30 for non-preferred brand name drugs for up to a 30-day supply at either a retail pharmacy or the mail service pharmacy.
    - 1. When a brand-name prescription drug is dispensed and an FDA-approved generic equivalent is available, the member will be responsible for the difference in cost between the generic drug and the non-preferred

brand-name drug, plus the non-preferred brand-name copayment (\$30).

iii. The copayment will be \$10 for generic drugs, \$30 for preferred brand name drugs and \$60 for non-preferred brand name drugs for a 31 to 90 day supply at a retail pharmacy.

1. When a brand-name prescription drug is dispensed and an FDA-approved generic equivalent is available, the member will be responsible for the difference in cost between the generic drug and the non-preferred brand-name drug, plus the non-preferred brand-name copayment (\$60).

iv. The copayment will be \$5 for generic drugs, \$20 for preferred brand name drugs and \$55 for non-preferred brand name drugs for a 31 to 90 day supply at the mail service pharmacy.

1. When a brand-name prescription drug is dispensed and an FDA-approved generic equivalent is available, the member will be responsible for the difference in cost between the generic drug and the non-preferred brand-name drug, plus the non-preferred brand-name copayment (\$55).

7. Effective March 31, 2005 the Empire Plan Centers of Excellence Programs will expand to include Cancer Resource Services. The Cancer Resource Services Program will provide:

- Direct telephonic nurse consultations;
- Information and assistance in locating appropriate care centers;
- Connection with cancer experts at Cancer Resource Services network facilities;
- A travel allowance of up to \$10,000; and
- Paid-in-full reimbursement for all services provided at a Cancer Resource Services network facility when the care is pre-certified.

8. Effective March 31, 2005 a Prosthetic and Orthotic network will be available to Empire Plan enrollees. Devices purchased through an

approved network provider will be paid-in-full under the participating provider component of the Empire Plan.

9. Effective March 31, 2005 the Empire Plan Basic Medical component will include the Basic Medical Provider Discount Program. This program offers discounts from certain physicians and other providers who are not part of the Empire Plan participating provider network but are an Empire Plan Multiplan provider. To be eligible to receive the Basic Medical Provider Discount Program the following conditions must be met:

- The Empire Plan is the primary coverage;
- Basic Medical services were received from a non-participating provider ;
- The non-participating provider is in the Multiplan network;
- The Multiplan provider discounted fee is lower than the Basic Medical reasonable and customary allowance; and
- The annual Basic Medical deductible has been met.

This benefit will sunset on or about December 31, 2006, unless extended by agreement of both parties.

10. Effective March 31, 2005 the Empire Plan infertility lifetime maximum benefit will increase to \$50,000 per covered individual.

11. Effective March 31, 2005 the Empire Plan hearing aid allowance will be \$1,200 per hearing aid per ear.

12. Effective March 31, 2005 Empire Plan mastectomy prosthetics will be a paid-in-full benefit.

13. Effective March 31, 2005 the Empire Plan maximum lifetime benefit for non-network substance abuse services will be increased to \$250,000

14. The State and the ALESU Joint Committee on Health Benefits will develop and implement two additional Empire Plan disease management programs.

15. The ALESU Joint Committee on Health Benefits will work with the State to implement a direct debit vehicle to be utilized under the Medical Flexible Spending Account.

16. Effective March 31, 2005 eligible expenses under the Medical Flexible Spending Account will be expanded to include over-the-counter medications according to guidelines developed by the Medical Flexible

Spending Account Administrator.

17. Effective March 31, 2005 the maximum annual Dental Care benefit per person will be increased to \$2,300.
18. Effective March 31, 2005 the maximum lifetime benefit for orthodontic treatment will increase to \$2,300.
19. The State will seek the appropriation of funds by the Legislature to support the ALESU Joint Committee on Health Benefits initiatives and to carry out the administrative responsibilities of the Committee in the amount of \$6,400 for the period April 1, 2003 to March 31, 2004 and \$6,400 for the period April 1, 2004 to March 31, 2005.
20. Effective March 31, 2005 the Vision Care Plan will be modified as follows:
  - a. Lasik and other similar vision care procedures performed to correct nearsightedness and/or farsightedness not covered by the Empire Plan or an HMO will be a covered service for employees only.
  - b. Corrective Vision Care coverage will only be available through a network of participating board eligible/board certified ophthalmologists trained in this field. The Vision Care Plan administrator will be responsible for the network and will make every effort to recruit and retain providers throughout New York State.
  - c. Corrective Vision Care coverage will include a preliminary exam, the actual procedure and up to two follow-up visits.
  - d. Employees receiving such services will have a copayment equal to 10% of the discounted cost of the procedure up to an out-of-pocket maximum of \$200.
  - e. Employees will be eligible for one Corrective Vision Care procedure every five (5) years per eye.
  - f. The ALESU Joint Committee on Health Benefits will review the Corrective Vision Care coverage component at regular intervals to monitor utilization, network adequacy and cost.
  - g. The five (5) year limit may be waived based on evidence of a significant vision change due to injury or illness.
  - h. Spouses/Domestic Partners and dependent children will be eligible to receive discounted (up to 25 percent) Laser Vision Correction

Services from a participating network provider. Any and all costs associated with such dependent Laser Vision Correction Services will be the responsibility of the employee.