



OCTOBER 2018

# HEALTH INSURANCE CHOICES FOR 2019 SUPPLEMENT

For active employees enrolled in NYSHIP through Participating Employers, their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees

This flyer is a companion document to the *Health Insurance Choices for 2019* booklet. It explains your benefits as an active employee enrolled in NYSHIP through a Participating Employer.

Please refer to this document in place of pages 16-25 in *Choices* for the best understanding of your Empire Plan benefits.



**NYSHIP**  
New York State  
Health Insurance Program

# THE EMPIRE PLAN NYSHIP CODE #001

Empire Plan benefits are available worldwide, and the Plan gives you the freedom to choose a participating or nonparticipating provider or facility. This section summarizes benefits available under each portion of The Empire Plan as of January 1, 2019.<sup>1</sup> You may also visit [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for additional information on the following programs.

## Medical/Surgical Program

### UnitedHealthcare

Medical and surgical coverage through:

- **Participating Provider Program** – More than 250,000 physicians and other providers participate; certain services are subject to a \$25 copayment.
- **Basic Medical Program** – If you use a nonparticipating provider, the Program considers up to 80 percent of usual and customary charges for covered services after the combined annual deductible is met. After the combined annual coinsurance maximum is met, the Plan considers up to 100 percent of usual and customary charges for covered services. See Cost Sharing (beginning on page 4) for additional information.
- **Basic Medical Provider Discount Program** – If you are Empire Plan primary and use a nonparticipating provider who is part of the Empire Plan MultiPlan group, your out-of-pocket costs may be lower (see page 5).

**Home Care Advocacy Program (HCAP)** – Paid-in-full benefits for home care, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes. (Diabetic shoes have an annual maximum benefit of \$500.) Prior authorization is required. Guaranteed access to network benefits nationwide. Limited non-network benefits available (see the *Empire Plan Certificate* for details).

**Managed Physical Medicine Program** – Chiropractic treatment, physical therapy and occupational therapy through a Managed Physical Network (MPN) provider are subject to a \$25 copayment. Unlimited network

benefits when medically necessary. Guaranteed access to network benefits nationwide. Non-network benefits available.

Under the **Benefits Management Program**, you must call the Medical/Surgical Program for Prospective Procedure Review before an elective (scheduled) magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET) scan or nuclear medicine test, unless you are having the test as an inpatient in a hospital (see the *Empire Plan Certificate* for details).

When arranged by the Medical/Surgical Program, a voluntary, paid-in-full specialist consultant evaluation is available. Voluntary outpatient medical case management is available to help coordinate services for catastrophic and complex cases.

## Hospital Program

### Empire BlueCross BlueShield

The following benefit levels apply for covered services received at a BlueCross and BlueShield Association BlueCard® PPO **network hospital**:

- Hospital inpatient stays are covered at no cost to you.
- Hospital outpatient and emergency care are subject to network copayments.
- Anesthesiology, pathology and radiology provider charges for covered hospital services are paid in full under the Medical/Surgical Program (if The Empire Plan provides your primary coverage).
- Certain covered outpatient hospital services provided at network hospital extension clinics are subject to hospital outpatient copayments.
- Except as noted above, physician charges received in a hospital setting will be paid in full if the provider is a participating provider under the Medical/Surgical Program. Physician charges for covered services received from a non-network provider will be paid in accordance with the Basic Medical portion of the Medical/Surgical Program.

<sup>1</sup> These benefits are subject to medical necessity and to limitations and exclusions described in the *Empire Plan Certificate* and *Empire Plan Reports/Certificate Amendments*.

If you are an Empire Plan-primary enrollee<sup>2</sup>, you will be subject to 10 percent coinsurance for inpatient stays at a **non-network hospital**. For outpatient services received at a non-network hospital, you will be subject to the greater of 10 percent coinsurance or \$75 per visit, up to the combined annual coinsurance maximums per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined (see page 5).

The Empire Plan will approve network benefits for hospital services received at a non-network facility if:

- Your hospital care is emergency or urgent
- No network facility can provide the medically-necessary services
- You do not have access to a network facility within 30 miles of your residence
- Another insurer or Medicare provides your primary coverage (pays first)

### Preadmission Certification Requirements

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

- Before a maternity or scheduled (nonemergency) hospital admission
- Within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission
- Before admission or transfer to a skilled nursing facility

If you do not follow the preadmission certification requirement for the Hospital Program, you must pay:

- A \$200 hospital penalty if it is determined any portion was medically necessary; and
- All charges for any day's care determined not to be medically necessary.

Voluntary inpatient medical case management is available to help coordinate services for catastrophic and complex cases.

## Mental Health and Substance Abuse Program

### Beacon Health Options Inc.

The Mental Health and Substance Abuse (MHSA) Program offers both network and non-network benefits.

### Network Benefits

(unlimited when medically necessary)

If you call the MHSA Program before you receive services and follow their recommendations, you receive:

- Inpatient services (paid in full)
- Crisis intervention (up to three visits per crisis paid in full; after the third visit, the \$25 copayment per visit applies)
- Outpatient services, including office visits, home-based or telephone counseling and nurse practitioner services (\$25 copayment)
- Intensive Outpatient Program (IOP) with an approved provider for substance use treatment (\$25 copayment)

### Non-Network Benefits<sup>3</sup>

(unlimited when medically necessary)

The following applies if you do **NOT** follow the requirements for network coverage.

- For Practitioner Services: The MHSA Program will consider up to 80 percent of usual and customary charges for covered outpatient practitioner services after you meet the combined annual deductible per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined. After the combined annual coinsurance maximum is reached per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined, the Program pays up to 100 percent of usual and customary charges for covered services (see page 5).

<sup>2</sup> If Medicare or another plan provides primary coverage, you receive network benefits for covered services at both network and non-network hospitals.

<sup>3</sup> You are responsible for ensuring that MHSA Program certification is received for care obtained from a non-network practitioner or facility.

- For Approved Facility Services: You are responsible for 10 percent of covered billed charges up to the combined annual coinsurance maximum per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined. After the coinsurance maximum is met, the Program pays 100 percent of billed charges for covered services (see page 5).
- Outpatient treatment sessions for family members of an individual being treated for alcohol or substance use are covered for a maximum of 20 visits per year for all family members combined.

## Empire Plan Cost Sharing

### Plan Providers

Under The Empire Plan, benefits are available for covered services when you use a participating or nonparticipating provider. However, your share of the cost of covered services depends on whether the provider you use participates in the Plan. You receive the maximum plan benefits when you use participating providers. For more information, read *Reporting On Network Benefits*. You can find this publication at [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) or ask your HBA for a copy.

**If you use an Empire Plan participating or network provider or facility,** you pay a copayment for certain services. Some services are covered at no cost to you. The provider or facility files the claim and is reimbursed by The Empire Plan.

You are guaranteed access to network benefits for certain services when you contact the program before receiving services and follow program requirements for:

- Mental Health and Substance Abuse (MHSA) Program services
- Managed Physical Medicine Program services (physical therapy, chiropractic care and occupational therapy)
- Home Care Advocacy Program (HCAP) services (including durable medical equipment)

**If you use an Empire Plan nonparticipating provider or non-network facility,** benefits for covered services are subject to a deductible and/or coinsurance.

### 2019 Annual Maximum Out-of-Pocket Limit

Your maximum out-of-pocket expenses for in-network covered services will be \$5,150 for Individual coverage and \$10,300 for Family coverage for Hospital, Medical/Surgical and MHSA Programs, combined. Once you reach the limit, you will have no additional copayments.

### Combined Annual Deductible

For Medical/Surgical and MHSA Program services received from a nonparticipating provider or non-network facility, The Empire Plan has a combined annual deductible of \$1,250 for the enrollee, \$1,250 for the enrolled spouse/domestic partner and \$1,250 for all dependent children combined. The combined annual deductible must be met before covered services under the Basic Medical Program and non-network expenses under both the HCAP and MHSA Programs can be reimbursed. The Managed Physical Medicine Program has a separate \$250 deductible per enrollee, \$250 per enrolled spouse/domestic partner and \$250 per all dependent children combined that is not included in the combined annual deductible.

After you satisfy the combined annual deductible, The Empire Plan considers 80 percent of the usual and customary charge for the Basic Medical Program and non-network practitioner services for the MHSA Program, 50 percent of the network allowance for covered services for non-network HCAP services and 90 percent of the billed charges for covered services for non-network approved facility services for the MHSA Program. You are responsible for the remaining 20 percent coinsurance and all charges in excess of the usual and customary charge for Basic Medical Program and non-network practitioner services, 10 percent for non-network MHSA-approved facility services and the remaining 50 percent of the network allowance for covered, non-network HCAP services.

## Combined Annual Coinsurance Maximum

The Empire Plan has a combined annual coinsurance maximum of \$3,750 for the enrollee, \$3,750 for the enrolled spouse/domestic partner and \$3,750 for all dependent children combined.

After you reach the combined annual coinsurance maximum, you will be reimbursed up to 100 percent of covered charges under the Hospital Program and 100 percent of the usual and customary charges for services covered under the Basic Medical Program and MHSa Program. You are responsible for paying the provider and will be reimbursed by the Plan for covered charges. You are also responsible for paying all charges in excess of the usual and customary charge.

The combined annual coinsurance maximum will be shared among the Basic Medical Program and non-network coverage under the Hospital Program and MHSa Program. The Managed Physical Medicine Program and HCAP do not have a coinsurance maximum.

## Basic Medical Provider Discount Program

If you are Empire Plan primary, The Empire Plan also includes a program to reduce your out-of-pocket costs when you use a nonparticipating provider. The Empire Plan Basic Medical Provider Discount Program offers discounts from certain physicians and providers who are not part of The Empire Plan participating provider network. These providers are part of the nationwide MultiPlan group, a provider organization contracted with UnitedHealthcare. Empire Plan Basic Medical Program provisions apply, and you must meet the combined annual deductible.

Providers in the Basic Medical Provider Discount Program accept a discounted fee for covered services. Your 20 percent coinsurance is based on the lower of the discounted fee or the usual and customary charge. Under this Program, the provider submits your claims, and UnitedHealthcare pays The Empire Plan portion of the provider fee directly to the provider if the services qualify for the Basic Medical Provider Discount Program. Your explanation of benefits, which details claims payments, shows the discounted amount applied to billed charges.

## The Empire Plan Center of Excellence Programs

**The Center of Excellence for Cancer Program** includes paid-in-full coverage for cancer-related services received through Cancer Resource Services (CRS). CRS is a nationwide network that includes many of the nation's leading cancer centers. The enhanced benefits, including a travel allowance within the United States, are available only when you are enrolled in the Program. Precertification is required.

**The Center of Excellence for Transplants Program** provides paid-in-full coverage for services covered under the Program and performed at a qualified Center of Excellence. The enhanced benefits, including a travel allowance within the United States, are available only when you are enrolled in the Program and The Empire Plan is your primary coverage. Precertification is required.

**The Center of Excellence for Infertility Program** is a select group of participating providers recognized as leaders in reproductive medical technology and infertility procedures. Benefits are paid in full, subject to the lifetime maximum benefit of \$50,000 per covered individual. A travel allowance within the United States is available. Precertification is required.

For details on the Empire Plan Centers of Excellence Programs, see the *Empire Plan Certificate and Reporting On Center of Excellence Programs* available at [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) or from your HBA.

To find a provider in the Empire Plan Basic Medical Provider Discount Program, ask if the provider is an Empire Plan MultiPlan provider or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447), choose the Medical Program and ask a representative for help. You can also go to [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits). Select your group and plan, if prompted, and then Find a Provider.

## Prescription Drug Program

### CVS Caremark

*The Prescription Drug Program does not apply to those who have drug coverage through a union Employee Benefit Fund.*

- When you use a network pharmacy, the mail service pharmacy or the specialty pharmacy for a 1- to 30-day supply of a covered drug, you pay a \$5 copayment for Level 1 or most generic drugs; a \$25 copayment for Level 2, preferred drugs or compound drugs; and a \$45 copayment for Level 3, certain generic drugs or non-preferred drugs.
- For a 31- to 90-day supply of a covered drug through a network pharmacy, you pay a \$10 copayment for Level 1 or most generic drugs; a \$50 copayment for Level 2, preferred drugs or compound drugs; and a \$90 copayment for Level 3, certain generic drugs or non-preferred drugs.
- For a 31- to 90-day supply of a covered drug through the mail service pharmacy or the specialty pharmacy, you pay a \$5 copayment for Level 1 or most generic drugs; a \$50 copayment for Level 2, preferred drugs or compound drugs; and a \$90 copayment for Level 3, certain generic drugs or non-preferred drugs.
- When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 or non-preferred copayment, plus the difference in cost between the brand-name drug and the generic equivalent (or “ancillary charge”), not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Flexible Formulary. Exceptions apply. Please contact the Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP (1-877-769-7447) for more information.
- The Empire Plan has a flexible formulary that excludes certain prescription drugs from coverage.
- Prior authorization is required for certain drugs.
- Oral chemotherapy drugs for the treatment of cancer do not require a copayment.
- Tamoxifen and Raloxifene, when prescribed for the primary prevention of breast cancer, do not require a copayment. In addition, generic oral contraceptive drugs and devices or brand-name drugs/devices without a generic equivalent (single-source brand-name drugs/devices) do not require a copayment. The copayment waivers for these drugs will only be provided if the drug is filled at a network pharmacy.
- Certain preventive adult vaccines, when administered at a pharmacy that participates in the CVS Caremark National Vaccine Network, do not require a copayment.
- A pharmacist is available 24 hours a day, seven days a week to answer questions about your prescriptions.
- You can use a non-network pharmacy or pay out of pocket at a network pharmacy (instead of using your Empire Plan Benefit Card) and submit a claim form for reimbursement. In almost all cases, you will not be reimbursed the total amount you paid for the prescription and your out-of-pocket expenses may exceed the usual copayment amount. To reduce your out-of-pocket expenses, use your Empire Plan Benefit Card whenever possible.

See the *Empire Plan Certificate/Reports* or contact the Plan for more information.

## 2019 Annual Maximum Out-Of-Pocket Limit\*

Your annual maximum out-of-pocket expenses for covered drugs received from a network pharmacy will be \$2,750 for Individual coverage and \$5,500 for Family coverage. Once you reach the limit, you will have no additional copayments for prescription drugs.

## Specialty Pharmacy

CVS Caremark Specialty Pharmacy is the designated pharmacy for The Empire Plan Specialty Pharmacy Program. The Program provides enhanced services to individuals using specialty drugs (such as those used to treat complex conditions and those that require special handling, special administration or intensive patient monitoring). The complete list of specialty drugs included in the Specialty Pharmacy Program is available on NYSHIP Online. Go to [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) and choose your group and plan, if prompted. Select Using Your Benefits and then Specialty Pharmacy Drug List.

The Program provides enrollees with enhanced services that include disease and drug education; compliance, side-effect and safety management; expedited, scheduled delivery of medications at no additional charge; refill reminder calls; and all necessary supplies (such as needles and syringes) applicable to the medication.

Under the Specialty Pharmacy Program, you are covered for an initial 30-day fill of most specialty medications at a retail pharmacy, but all subsequent fills must be obtained through the designated specialty pharmacy. When CVS Caremark dispenses a specialty medication, the applicable mail service copayment is charged. To get started with CVS Caremark Specialty Pharmacy, request refills or speak to a specialty-trained pharmacist or nurse, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447). Choose the Prescription Drug Program and ask to speak with Specialty Customer Care.

## Medicare-primary enrollees and dependents:

If you are or will be Medicare primary in 2019, ask your HBA for a copy of *2019 Choices for Retirees* for information about your coverage under Empire Plan Medicare Rx, a Medicare Part D prescription drug program.

## The Empire Plan NurseLine<sup>SM</sup>

Call The Empire Plan and press or say 5 for the NurseLine<sup>SM</sup> for health information and support.

Representatives are available 24 hours a day, seven days a week.

## Contact The Empire Plan

For additional information or questions on any of the benefits described here, call the Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the applicable program.

## Teletypewriter (TTY) Numbers

These numbers are available to callers who use a TTY device because of a disability and are all toll free.

### Medical/Surgical Program

TTY only:..... 1-888-697-9054

### Hospital Program

TTY only:.....1-800-241-6894

### Mental Health and Substance Abuse Program

TTY only:..... 1-855-643-1476

### Prescription Drug Program

TTY only:..... 711

\* The annual maximum out-of-pocket limit does not apply to Empire Plan Medicare Rx.

## THE EMPIRE PLAN

For active employees enrolled in NYSHIP through Participating Employers, their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees.

Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
Office Visits <sup>2</sup>		\$25 per visit	Basic Medical <sup>3</sup>
Specialty Office Visits <sup>2</sup>		\$25 per visit	Basic Medical <sup>3</sup>
<b>Diagnostic Services:</b> <sup>2</sup>			
Radiology	\$50 per outpatient visit	\$25 per visit	Basic Medical <sup>3</sup>
Lab Tests	\$50 per outpatient visit	\$25 per visit	Basic Medical <sup>3</sup>
Pathology	No copayment	\$25 per visit	Basic Medical <sup>3</sup>
EKG/EEG	\$50 per outpatient visit	\$25 per visit	Basic Medical <sup>3</sup>
Radiation, Chemotherapy, Dialysis	No copayment	No copayment	Basic Medical <sup>3</sup>
<b>Women's Health Care/OB GYN:</b> <sup>2</sup>			
Screenings and Maternity-Related Lab Tests	\$50 per outpatient visit	\$25 per visit	Basic Medical <sup>3</sup>
Mammograms	No copayment	No copayment	Basic Medical <sup>3</sup>
Pre/Postnatal Visits and Well-Woman Exams		\$25 per visit	Basic Medical <sup>3</sup>
Bone Density Tests	\$50 per outpatient visit	\$25 per visit	Basic Medical <sup>3</sup>
Breastfeeding Services and Equipment		No copayment for pre/postnatal counseling and equipment purchase from a participating provider; one double-electric breast pump per birth	
<b>Family Planning Services</b> <sup>2</sup>		\$25 per visit	Basic Medical <sup>3</sup>
<b>Infertility Services</b> <sup>4</sup>	\$50 per outpatient visit	\$25 per visit; no copayment at designated Centers of Excellence <sup>4</sup>	Basic Medical <sup>3</sup>
<b>Contraceptive Drugs and Devices</b>		No copayment for certain FDA-approved oral contraception methods (including outpatient surgical implantation) and counseling	Basic Medical <sup>3</sup>



Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Inpatient Hospital Surgery</b>	No copayment <sup>5</sup>	No copayment	Basic Medical <sup>3</sup>
<b>Outpatient Surgery</b>	\$95 per visit	\$25 per visit <sup>6</sup>	Basic Medical <sup>3</sup>
<b>Emergency Department</b>	\$100 per visit <sup>7</sup>	No copayment	Basic Medical <sup>3,8</sup>
<b>Urgent Care</b>	\$50 per outpatient visit <sup>9</sup>	\$30 per visit	Basic Medical <sup>3</sup>
<b>Ambulance</b>	No copayment <sup>10</sup>	\$70 per trip <sup>11</sup>	\$70 per trip <sup>11</sup>
<b>Mental Health Practitioner Services</b>		\$25 per visit	Applicable annual deductible, 80% of usual and customary, after applicable coinsurance max, 100% of usual and customary (see pages 4–5 for details)
<b>Approved Facility Mental Health Services</b>		No copayment	90% of billed charges; after applicable coinsurance max, covered in full (see pages 4–5 for details)
<b>Outpatient Drug/Alcohol Rehabilitation</b>		\$25 per visit to approved Intensive Outpatient Program	Applicable annual deductible, 80% of usual and customary, after applicable coinsurance max, 100% of usual and customary (see pages 4–5 for details)

<sup>1</sup> Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical/Surgical Program. Non-network hospital coverage provided subject to coinsurance (see page 2).

<sup>2</sup> Copayment waived for preventive services under the Patient Protection and Affordable Care Act (PPACA). See [www.hhs.gov/healthcare/rights/preventive-care](http://www.hhs.gov/healthcare/rights/preventive-care) or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

<sup>3</sup> See Cost Sharing (beginning on page 4) for Basic Medical information.

<sup>4</sup> Certain qualified procedures require precertification and are subject to a \$50,000 lifetime allowance.

<sup>5</sup> Preadmission certification required.

<sup>6</sup> In outpatient surgical locations (Medical/Surgical Program), the copayment for the facility charge is \$50 per visit or Basic Medical benefits apply, depending upon the status of the center. (Check with the center or The Empire Plan program administrators.)

<sup>7</sup> Copayment waived if admitted.

<sup>8</sup> Attending emergency department physicians and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and/or pathology services are paid in full. Other providers are considered under the Basic Medical Program and are not subject to deductible or coinsurance.

<sup>9</sup> At a hospital-owned urgent care facility only.

<sup>10</sup> If service is provided by admitting hospital.

<sup>11</sup> Ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and the type of ambulance transportation is required because of an emergency situation.

## THE EMPIRE PLAN

Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Inpatient Drug/Alcohol Rehabilitation</b>		No copayment	90% of billed charges; after applicable coinsurance max, covered in full (see pages 4–5 for details)
<b>Durable Medical Equipment</b>		No copayment (HCAP)	50% of network allowance (see the <i>Empire Plan Certificate/Reports</i> )
<b>Prosthetics</b>		No copayment <sup>12</sup>	Basic Medical <sup>3,12</sup> \$1,500 lifetime maximum benefit for prosthetic wigs, not subject to deductible or coinsurance
<b>Orthotic Devices</b>		No copayment <sup>12</sup>	Basic Medical <sup>3,12</sup>
<b>External Mastectomy Prostheses</b>		No network benefit. See nonparticipating provider.	Paid-in-full benefit for one single or double prosthesis per calendar year under Basic Medical, not subject to deductible or coinsurance <sup>3,12</sup>
<b>Rehabilitative Care</b> (not covered in a skilled nursing facility if Medicare primary)	No copayment as an inpatient; \$25 per visit for outpatient physical therapy following related surgery or hospitalization <sup>13</sup>	Physical or occupational therapy \$25 per visit (MPN) Speech therapy \$25 per visit	\$250 annual deductible, 50% of network allowance Basic Medical <sup>3</sup>
<b>Diabetic Supplies</b>		No copayment (HCAP)	50% of network allowance (see the <i>Empire Plan Certificate/Reports</i> )
<b>Insulin and Oral Agents</b> (covered under the Prescription Drug Program, subject to drug copayment)			
<b>Diabetic Shoes</b>		\$500 annual maximum benefit	75% of network allowance up to an annual maximum benefit of \$500 (see the <i>Empire Plan Certificate/Reports</i> )
<b>Hospice</b>	No copayment, no limit		10% of billed charges up to the combined annual coinsurance maximum
<b>Skilled Nursing Facility<sup>14,15</sup></b>	No copayment		10% of billed charges up to the combined annual coinsurance maximum

Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Prescription Drugs</b> (see page 6)			
Specialty Drugs (see page 7)			
<b>Additional Benefits</b>			
Dental (preventive)		Not covered	Not covered
Vision (routine only)		Not covered	Not covered
Hearing Aids		No network benefit. See nonparticipating provider.	Up to \$1,500 per aid per ear every 4 years (every 2 years for children) if medically necessary
Annual Out-of-Pocket Maximum	Individual coverage: \$2,750 for the Prescription Drug Program. <sup>15</sup> \$5,150 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Abuse Programs. Family coverage: \$5,500 for the Prescription Drug Program. <sup>15</sup> \$10,300 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Abuse Programs.		Not available
Out-of-Area Benefit	Benefits for covered services are available worldwide.		
24-hour NurseLine <sup>SM</sup> for health information and support at 1-877-7-NYSHIP (1-877-769-7447).			
Voluntary disease management programs available for conditions such as asthma, attention deficit hyperactivity disorder (ADHD), cardiovascular disease, chronic kidney disease (CKD), chronic obstructive pulmonary disease, congestive heart failure, depression, diabetes and eating disorders.			
Diabetes education centers for enrollees who have a diagnosis of diabetes.			
For more information regarding covered vaccines, tests and screenings, see the <i>Empire Plan Preventive Care Coverage Chart</i> on NYSHIP Online under Publications or visit <a href="http://www.hhs.gov/healthcare/rights/preventive-care">www.hhs.gov/healthcare/rights/preventive-care</a> .			
<sup>1</sup> Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical/Surgical Program. Non-network hospital coverage provided subject to coinsurance (see page 2). <sup>2</sup> Copayment waived for preventive services under the PPACA. See <a href="http://www.hhs.gov/healthcare/rights/preventive-care">www.hhs.gov/healthcare/rights/preventive-care</a> or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance. <sup>3</sup> See Cost Sharing (beginning on page 4) for Basic Medical information.	<sup>12</sup> Benefit paid up to cost of device meeting individual's functional need. <sup>13</sup> Physical therapy must begin within six months of the related surgery or hospitalization and be completed within 365 days of the related surgery or hospitalization. <sup>14</sup> Up to 120 benefit days; Benefits Management Program provisions apply. <sup>15</sup> Does not apply to Medicare-primary enrollees.		

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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](http://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. COBRA and Young Adult Option enrollees, contact the Employee Benefits Division.

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

Care has been taken to ensure the accuracy of the material contained in this booklet. However, the HMO contracts and the *Empire Plan Certificate of Insurance with Amendments* are the controlling documents for benefits available under NYSHIP.