October 2017

Health Insurance Choices for 2018

For employees of the State of New York, Participating Employers, their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees

NYSHIP
New York State
Health Insurance Program

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Information & Reminders

Make Your Health Plan Choices

This booklet explains the options available to you under the New York State Health Insurance Program (NYSHIP) for your health insurance and other elections. You may choose coverage under The Empire Plan or one of the NYSHIP-approved health maintenance organizations (HMOs) in your area. Or, if you can be covered under other employer-sponsored group health benefits, you may be eligible to elect the Opt-out Program.*

Consider your options carefully. You may not change your option after the deadline, except in special circumstances (see your *NYSHIP General Information Book* and *Empire Plan Reports* or *HMO Reports* for details about changing options outside the Option Transfer Period). If you still have questions after you have read the information in this booklet, contact your Health Benefits Administrator (HBA) or The Empire Plan program administrators and HMOs directly.

Rates for 2018 and Deadline for Changing Plans

The Empire Plan and HMO rates for 2018 will be mailed to your home and posted on our website, NYSHIP Online, as soon as they are approved. To find this information online, go to www.cs.ny.gov/employee-benefits. Next, select your group and plan, if prompted, and then Health Benefits & Option Transfer. Choose Rates and Health Plan Choices.

Note: Participating Employers (PEs), such as the Thruway Authority and the Metropolitan Transportation Authority, will notify their enrollees of 2018 rates.

The rate flyer announces the option-change deadline and dates that changes in health insurance payroll deductions will occur. You will have 30 days from the date your agency receives rate information to make a decision. Your HBA can help if you have questions. COBRA and Young Adult Option enrollees may contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (United States, Canada, Puerto Rico and the Virgin Islands).

* The Opt-out Program is available to eligible NYS employees who have other employer-sponsored group health insurance. Check with your HBA if you have any questions about your eligibility for the Opt-out Program. Employees of Participating Employers in NYSHIP should check with their HBA to determine if their employer offers a program similar to the Opt-out Program. See page 15 for more information about this program.

Changing Your 2018 Pre-Tax Contribution Program (PTCP) Status (November 30, 2017 Deadline)

PTCP does not apply to COBRA and Young Adult Option enrollees or retirees. The following also may not apply to Participating Employers. PEs that participate in a pre-tax contribution program will provide specific pre-tax information to their employees.

Under PTCP, your share of the health insurance premium is deducted from your wages before taxes are withheld, which may lower your tax liability.

NO ACTION IS REQUIRED TO KEEP YOUR CURRENT PTCP STATUS.

If you wish to change your PTCP selection for 2018, submit a signed and completed *Health Insurance Transaction Form* (PS-404) to your HBA between November 1 and November 30, 2017.

Checking Your PTCP Status

Your paycheck shows whether or not you are enrolled in PTCP.

- If you are enrolled in PTCP, your paycheck stub shows "Regular Before-Tax Health" in the Before-Tax Deductions section. Your health insurance premium is deducted from your wages before taxes are withheld.
- If you are not enrolled in PTCP, or part of your deduction is being taken after tax (e.g., for a non-federally qualifying dependent), your paycheck stub shows "Regular After-Tax Health" in the After-Tax Deductions section. Your health insurance premium is deducted from your wages after taxes are withheld.

New Enrollees

When enrolling in NYSHIP coverage, new enrollees must elect whether or not to participate in PTCP. No election will be made automatically on the enrollee's behalf. Enrollment cannot be completed without a PTCP election.

PTCP Enrollment Limits Mid-Year Changes

Under Internal Revenue Service (IRS) rules, if you are enrolled in PTCP, you may not change your **pre-tax payroll deduction for health benefits** during the plan year (by changing your health benefit option, changing your coverage [Family or Individual] or by canceling coverage) unless a PTCP-qualifying event occurs. Requests to change your pre-tax deduction during the tax year must be consistent (for all individuals covered under the contract) with qualifying life events and must be requested within 30 days of the event. You may not change your pre-tax payroll deduction for health benefits (other than during the PTCP Enrollment Period or Option Transfer Period), except when one of the following PTCP-qualifying events occurs:

- Change in marital status
- Change in number of dependents
- Change in your (or your dependent's) employment status that affects eligibility for health benefits
- Your dependent satisfies or ceases to satisfy eligibility requirements for health benefits
- Change in your (or your dependent's) place of residence or worksite that affects eligibility for benefits
- Significant change in health benefits and/or premium under NYSHIP
- Significant change in health benefits and/or premium under your (or your dependent's) other employer's plan
- COBRA events
- Judgment, decree or order to provide health benefits to eligible dependents
- Medicare or Medicaid eligibility
- Leaves of absence
- HIPAA special enrollment rights

A coverage change due to a qualifying event must be requested within 30 days of the event (or within the waiting period if newly eligible); delays may be costly.

See your HBA to change your health insurance option, type of coverage or pre-tax status.

NO ACTION IS REQUIRED IF YOU DO NOT WISH TO MAKE CHANGES (unless you wish to continue enrollment in the **Opt-out Program**; see page 15). Changes are not automatic, and deadlines apply. You must report any change that may affect your coverage to your HBA. See pages 1-3 in this booklet and your *NYSHIP General Information Book* for complete information.

Your Share of the Premium

The following does not apply to employees of Participating Employers (PEs). PEs will provide premium information. It also does not apply to COBRA enrollees, Young Adult Option enrollees or enrollees in Leave Without Pay status (who pay the full cost of coverage).

New York State helps pay for your health insurance coverage. After the State's contribution, you are responsible for paying the balance of your premium, usually through biweekly deductions from your paycheck.

Whether you enroll in The Empire Plan or in a NYSHIP HMO, the State's share and your share of the cost of coverage are based on the following (salary requirements vary; contact your HBA for more information):

Enrollee Pay Grade	Individual Coverage		Dependent Coverage	
	State Share	Employee Share	State Share	Employee Share
Grade 9 and below*	88%	12%	73%	27%
Grade 10 and above*	84%	16%	69%	31%

* Or salary equivalent, if no Grade assigned. Contact your HBA to confirm.

If you enroll in a NYSHIP HMO, the State's dollar contribution for the hospital, medical/surgical and mental health and substance abuse components of your HMO premium will not exceed its dollar contribution for those components of The Empire Plan premium. For the prescription drug component of your HMO premium, the State pays the share noted in the table; the dollar amount is not limited by the cost of Empire Plan drug coverage.

As soon as they are approved, 2018 rates will be mailed to your home and posted on NYSHIP Online at www.cs.ny.gov/employee-benefits. Select your group and plan, if prompted, and then Health Benefits & Option Transfer. Choose Rates and Health Plan Choices.

Let Your Agency Know about Changes

You must notify your HBA if your home address or phone number changes. If you are an active employee of New York State and registered for MyNYSHIP, you may also make address and option changes online. **Note:** MyNYSHIP is not available for active employees of PEs.

Changes in your family status, such as gaining or losing a dependent, may mean you need to change your health insurance coverage from Individual to Family or from Family to Individual. If you submit a request within 30 days after a change in family status, you may make changes outside the Option Transfer Period without experiencing a waiting period. See your *NYSHIP General Information Book* for details. Promptly inform your HBA about any change to ensure it is effective on the actual date of change in family status.

If You Retire or Leave State Service in 2018

If you continue your NYSHIP enrollment as a retiree or vestee, you may change your health insurance plan when your status changes. As a retiree or vestee, you may change health insurance options at any time once during a 12-month period. For more information on changing options as a retiree or vestee, ask your HBA for *2018 Choices* for Retirees.

If You Become Eligible for Medicare in 2018

If you or a dependent is eligible for Medicare because of age or disability, see Medicare and NYSHIP on page 6 for important information. Please read this Medicare section if you or any dependent will be turning 65 in 2018 or if you are planning to retire in the coming year and will become Medicare primary.

Comparing Your NYSHIP Options

Choosing the option that best meets your needs and the needs of your family requires careful consideration. As with most important purchases, there is more to consider than cost.

The first step toward making a good choice is understanding the similarities and differences between your NYSHIP options. There are two types of health insurance plans available to you under NYSHIP: The Empire Plan and NYSHIP HMOs. The Empire Plan is available to all employees. NYSHIP HMOs are available in various geographic areas of New York State. Depending on where you live or work, one or several NYSHIP HMOs will be available to you. The Empire Plan and NYSHIP HMOs are similar in many ways but also have important differences.

Additionally, if you have other employer-sponsored group health benefits available to you, you may be eligible for the Opt-out Program (see page 15 for details).

Benefits

The Empire Plan and NYSHIP HMOs

- All NYSHIP plans provide a wide range of hospital, medical/surgical and mental health and substance abuse coverage.
- All plans provide prescription drug coverage for those who do not receive it through a union Employee Benefit Fund.
- All plans provide coverage for certain preventive care services as required by the federal Patient Protection and Affordable Care Act (PPACA). For more information on preventive care services, visit www.hhs.gov/healthcare/rights/preventive-care or NYSHIP Online.

Benefits differ among plans. Read this booklet and the Empire Plan Certificate (available from your HBA) and HMO contracts (available from each HMO) for details.

Exclusions

- All plans contain coverage exclusions for certain services and prescription drugs.
- Workers' compensation-related expenses and custodial care generally are excluded from coverage.

For details on a plan's exclusions, read the *Empire Plan Certificate* or the NYSHIP HMO contract or check with the plan directly.

Geographic Area Served

The Empire Plan

Benefits for covered services, not just urgent and emergency care, are available worldwide. However, access to **network benefits** is not guaranteed in all states and regions.

Health Maintenance Organizations (HMOs)

- Coverage is available in each HMO's specific service area.
- An HMO may arrange for coverage of care received outside its service area at its discretion in certain circumstances. See the out-of-area benefit description on each HMO page for more detailed information.

Terms To Know

Coinsurance: The enrollee's share of the cost of covered services, which is a fixed percentage of covered medical expenses.

Copayment: The enrollee's share of the cost of covered services, which is a fixed dollar amount paid when a medical service is received, regardless of the total charge for the service.

Deductible: The dollar amount an enrollee is required to pay before health plan benefits begin to reimburse for services. This amount applies when you use non-network providers.

Fee-for-service: A method of billing for health care services. A provider charges a fee each time an enrollee receives a service.

Formulary: A list of preferred drugs used by a health plan. A plan with a **closed formulary** provides coverage only for drugs that appear on the list. An **open** or **incented formulary** encourages use of preferred drugs to non-preferred drugs based on a tiered copayment schedule. In a **flexible formulary**, brand-name prescription drugs may be assigned to different copayment levels based on value to the plan and clinical judgment. In some cases, drugs may be excluded from coverage under a flexible formulary if a therapeutic equivalent is covered or available as an over-the-counter drug.

Health Benefits Administrator (HBA): An individual responsible for providing benefits assistance to active State employees. HBAs work with the Employee Benefits Division in the Department of Civil Service to process transactions and answer questions regarding eligibility and enrollment. You are responsible for notifying your HBA of changes that affect your enrollment and/or your or your dependents' eligibility for benefits.

Health Maintenance Organization (HMO): A managed-care system organized to deliver health care services in a geographic area. An HMO provides a predetermined set of benefits through a network of selected physicians, laboratories and hospitals for a prepaid premium. Except for emergency services and other services approved by your HMO, you and your enrolled dependents may have coverage only for services received from your HMO's network. See NYSHIP Health Maintenance Organizations on pages 9 and 10 for more information on HMOs.

Managed Care: A health care program designed to ensure you receive the highest quality medical care for the lowest cost in the most appropriate health care setting. Most managed-care plans require you to select a primary care physician employed by (or who contracts with) the managed health care system. He or she serves as your health care manager by coordinating virtually all health care services you receive. Your primary care physician provides your routine medical care and refers you to a specialist if necessary.

Medicare: A federal health insurance program that covers certain people age 65 or older, disabled persons under 65 and those who have end-stage renal disease (permanent kidney failure). Medicare is directed by the federal Centers for Medicare & Medicaid Services (CMS), and enrollment in Medicare is administered by the Social Security Administration.

Medicare Advantage Plan: A Medicare option wherein the plan agrees with Medicare to accept a fixed monthly payment for each Medicare enrollee. In exchange, the plan provides or pays for all medical care needed by the enrollee. If you join a Medicare Advantage Plan, you replace your original (fee-for-service) Medicare coverage (Parts A and B) with benefits offered by the plan and all of your medical care (except for emergency or out-of-area, urgently needed care) must be provided, arranged or authorized by the Medicare Advantage Plan. All NYSHIP Medicare Advantage HMOs include Medicare Part D drug coverage. The benefits under these plans are set in accordance with federal guidelines for Medicare Advantage Plans.

Network: A group of doctors, hospitals and/or other health care providers who participate in a health plan and agree to follow the plan's procedures.

New York State Health Insurance Program (NYSHIP): NYSHIP covers more than 1.2 million public employees, retirees and dependents. It is one of the largest group health insurance programs in the country. The Program provides health care benefits through The Empire Plan and NYSHIP-approved HMOs.

Option: A health insurance plan offered through NYSHIP. Options include The Empire Plan and NYSHIP-approved HMOs within specific geographic areas. The Opt-out Program (NYSHIP code #700) is also considered a NYSHIP option.

Primary/Medicare primary: A health insurance plan is primary when it is responsible for paying health benefits claims before any other group health insurance plan. It is important to understand when Medicare will become primary to your NYSHIP coverage. Read plan documents for complete information.

NYSHIP's Young Adult Option

During the Option Transfer Period, eligible adult children of NYSHIP enrollees can enroll in the Young Adult Option and current Young Adult Option enrollees are able to switch plans. This option allows unmarried, young adult children up to age 30 to purchase their own NYSHIP coverage. The premium is the full cost of Individual coverage for the option selected.

Young Adult Option Website

For more information about the Young Adult Option, go to www.cs.ny.gov/yao and choose the young adult's parent's employer group. From your group-specific page, you can download enrollment forms, review plan materials and compare rates for The Empire Plan and all NYSHIP HMOs.

This site is your best resource for information on NYSHIP's Young Adult Option. If you have additional questions, please contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344.

Medicare & NYSHIP

If you are an active employee, NYSHIP (The Empire Plan or a NYSHIP HMO) provides primary coverage for you and your dependents, regardless of age or disability. **Exceptions:** Medicare is primary for domestic partners age 65 or older or for an active employee or dependent of an active employee with end-stage renal disease (following a 30-month coordination period).

NYSHIP requires you and your dependents to be enrolled in Medicare Parts A and B when first eligible for Medicare coverage that pays primary to NYSHIP.

If you are planning to retire and you or your spouse is 65 or older, contact your Social Security office three months before active employment ends to enroll in Medicare Parts A and B. Medicare becomes primary to your NYSHIP coverage the first day of the month following a "runout" period of 28 days after the end of the payroll period in which you retire.*

If you or a dependent is eligible for Medicare coverage primary to NYSHIP and you don't enroll in Parts A and B, The Empire Plan or HMO will not provide benefits for services Medicare would have paid if you or your dependent had enrolled.**

If you are planning to retire or vest in 2018, learn how primary Medicare coverage will affect NYSHIP:

- **If you are enrolled in original Medicare (Parts A and B) and The Empire Plan:** Because Medicare does not provide coverage outside the United States, The Empire Plan pays primary for covered services received outside the United States.
- **If you enroll in a NYSHIP HMO Medicare Advantage Plan:** You replace your original Medicare coverage with benefits offered by the Medicare Advantage Plan. Benefits and networks under the HMO's Medicare Advantage Plan may differ from your coverage as an active employee. To qualify for benefits, you must follow plan rules.
- **If you enroll in a NYSHIP HMO that coordinates coverage with Medicare:** You receive the same benefits from the HMO as an active employee and still qualify for original Medicare benefits if you receive services not covered through your HMO.

Medicare Part D is the prescription drug benefit for Medicare-primary persons. Medicare-primary Empire Plan enrollees and dependents are enrolled automatically in Empire Plan Medicare Rx, a Part D prescription drug program. NYSHIP Medicare Advantage HMOs also provide Medicare Part D prescription drug coverage. You can be enrolled in only one Medicare product at a time. **Enrolling in a Medicare Part D plan or Medicare Advantage Plan separate from your NYSHIP coverage may drastically reduce your benefits overall, and in most cases you will be automatically disenrolled from your NYSHIP Plan.** For example:

- If you are a Medicare-primary Empire Plan enrollee or dependent and get your prescription drug coverage through Empire Plan Medicare Rx and then you enroll in another Medicare Part D plan outside of NYSHIP, the Centers for Medicare & Medicaid Services (CMS) will terminate your coverage in Empire Plan Medicare Rx. Because you must be enrolled in Empire Plan Medicare Rx to maintain Empire Plan coverage, in most cases, you and your covered dependents will lose all coverage under The Empire Plan.
- If you are enrolled in a NYSHIP Medicare Advantage HMO and then enroll in a Medicare Part D plan outside of NYSHIP, CMS will terminate your enrollment in the HMO.

If you have been approved for Extra Help by Medicare and you are enrolled in The Empire Plan or a NYSHIP Medicare Advantage HMO, you may be reimbursed for some or all of your cost for Medicare Part D coverage. For information about qualifying for Extra Help, contact Medicare. If you have been approved for Extra Help, contact the Employee Benefits Division or your HMO.

If you receive prescription drug coverage through a union Employee Benefit Fund, contact the fund for information about Medicare Part D.

For more information about NYSHIP and Medicare, see your *NYSHIP General Information Book* or ask your HBA for a copy of *2018 Choices* for Retirees, *Planning for Retirement* or *Medicare & NYSHIP.*

* If you are an employee of a PE, you may have a different "runout" period. Verify with your HBA.

** If you are asked to pay a Part A premium, see your HBA for more information.

Benefits Provided by All Plans

- Inpatient medical/surgical hospital care
- Outpatient medical/surgical hospital services
- Physician services
- Emergency services*
- Laboratory services
- Radiology services
- Chemotherapy
- Radiation therapy
- Dialysis
- Diagnostic services
- Diabetic supplies
- Maternity, prenatal care
- Well-child care
- Chiropractic services
- Skilled nursing facility services
- Physical therapy
- Occupational therapy
- Speech therapy
- Prosthetics and durable medical equipment
- Orthotic devices
- Medically-necessary bone density tests
- Mammography
- Inpatient mental health services
- Outpatient mental health services
- Alcohol and substance use detoxification
- Inpatient alcohol rehabilitation
- Inpatient drug rehabilitation
- Outpatient alcohol and drug rehabilitation
- Family planning and certain infertility services (call The Empire Plan program administrators or NYSHIP HMOs for details)
- Out-of-area emergencies
- Hospice benefits (at least 210 days)
- Home health care in lieu of hospitalization
- Prescription drug coverage including injectable and self-injectable medications, contraceptive drugs and devices and fertility drugs (unless you have coverage through a union Employee Benefit Fund)
- Enteral formulas covered through either the Home Care Advocacy Program (HCAP) for The Empire Plan or the NYSHIP HMO's prescription drug program (unless you have coverage through a union Employee Benefit Fund)
- Second opinion for cancer diagnosis

Please see the individual plan descriptions in this booklet to review the differences in coverage and out-of-pocket expenses. See plan documents for complete information on benefits.

* Some plans may exclude coverage for airborne ambulance services. Call The Empire Plan or your NYSHIP HMO for details.

The Empire Plan or a NYSHIP HMO

What's New?

The Empire Plan

For 2018, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan will be $7,350 for Individual coverage and $14,700 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. **See table below for more information about how out-of-pocket limits apply to each Empire Plan program.**

The Empire Plan

The Empire Plan is a unique plan designed exclusively for New York State's public employees. The Empire Plan has many managed-care features, but enrollees are not required to choose a primary care physician and do not need referrals to see specialists. However, certain services, such as hospital and skilled nursing facility admissions, certain outpatient radiological tests, certain mental health and substance use treatment/services, home care and some prescription drugs, require preapproval.

The Empire Plan is self-insured, and the New York State Department of Civil Service contracts with qualified companies to administer the Plan.

The Empire Plan provides:

- Network and non-network inpatient and outpatient hospital coverage for medical, surgical and maternity care
- Medical and surgical coverage under the Participating Provider Program or the Basic Medical Program and Basic Medical Provider Discount Program if you choose a nonparticipating provider
- Home care services, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes through the Home Care Advocacy Program (HCAP)
- Chiropractic treatment, physical therapy and occupational therapy coverage through the Managed Physical Medicine Program
- Inpatient and outpatient mental health and substance use coverage
- Prescription drug coverage, unless it is provided by a union Employee Benefit Fund
- Center of Excellence Programs for cancer, transplants and infertility
- 24-hour Empire Plan NurseLine℠ for health information and support
- Worldwide coverage

2018 Empire Plan Maximum Out-of-Pocket Limits for In-Network Services			
Coverage Type	Prescription Drug Program*	Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs, Combined	Total
Individual Coverage	$2,550	$4,800	$7,350
Family Coverage	$5,100	$9,600	$14,700

* Does not apply to Medicare-primary enrollees or the dependents of Medicare-primary enrollees.

Providers

Under The Empire Plan, you can choose from more than 250,000 participating physicians and other providers and facilities nationwide and from more than 68,000 participating pharmacies across the United States or a mail service pharmacy.

Some licensed nurse practitioners and convenience care clinics participate with The Empire Plan. Be sure to confirm participation before receiving care.

Under the Guaranteed Access benefit, The Empire Plan provides access to network benefits for covered services provided by primary care physicians and certain specialists when you are Empire Plan primary and you do not have access to a network provider within a reasonable distance from your residence. This benefit is available in New York State and specific counties in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont that share a border with New York State. **Note:** This benefit does not apply to enrollees of Participating Employers.

NYSHIP Health Maintenance Organizations

A health maintenance organization (HMO) is a managed-care system in a specific geographic area that provides comprehensive health care coverage through a network of providers.

- Coverage for services received outside the specified geographic area is limited. HMO enrollees who use doctors, hospitals or pharmacies outside the HMO's network must, in most cases, pay the full cost for services unless authorized by the HMO or in the case of an emergency.
- Enrollees usually choose a primary care physician (PCP) from the HMO's network for routine medical care and for referrals to specialists and hospitals when medically necessary.
- HMO enrollees usually pay a copayment as a per-visit fee or coinsurance (percentage of cost).
- HMOs have no annual deductible.
- Referrals to network specialists may be required.
- Claim forms are rarely required.

All NYSHIP HMOs provide a wide range of health services. Each offers a specific package of hospital, medical, surgical and preventive care benefits. These services are provided or arranged by the PCP selected by the enrollee from the HMO's network.

Consider Cost

When considering cost, think about all your costs throughout the year, not just your biweekly paycheck deduction. Keep in mind any out-of-pocket expenses you are likely to incur during the year, such as copayments for prescriptions and other services, coinsurance and any costs of using providers or services not covered under the plan. Watch for the *NYSHIP Rates & Deadlines for 2018* flyer that will be mailed to your home and posted on our website, www.cs.ny.gov/employee-benefits, as soon as rates are approved. (**Note:** PEs will provide premium information to their employees.) Along with this booklet, which provides copayment information, *NYSHIP Rates & Deadlines for 2018* will provide the information you need to determine your annual cost under each of the available plans.

All NYSHIP HMOs cover inpatient and outpatient hospital care at a network hospital and prescription drug coverage.*

NYSHIP HMOs are organized in one of two ways:

- A network HMO provides medical services through its own health centers, as well as through outside participating physicians, medical groups and multispecialty medical centers.
- An Independent Practice Association (IPA) HMO provides medical services through private practice physicians who have contracted independently with the HMO to provide services in their offices.

A member enrolling in either a network or IPA model HMO may be able to select a doctor he or she already uses if that doctor participates with the HMO.

See the individual HMO pages in this booklet for additional benefit information and to learn which HMOs serve your geographic area.

NYSHIP HMOs and Medicare

If you are Medicare primary, see page 6 for an explanation of how Medicare affects your NYSHIP HMO coverage.

Summary of Benefits and Coverage

The *Summary of Benefits and Coverage* (*SBC*) is a standardized comparison document required by the Patient Protection and Affordable Care Act (PPACA).

To view a copy of an *SBC* for The Empire Plan or a NYSHIP HMO, visit www.cs.ny.gov/sbc. If you do not have internet access, call 1-877-7-NYSHIP (1-877-769-7447) and select the Medical Program to request a copy of the *SBC* for The Empire Plan. If you need an *SBC* for a NYSHIP HMO, contact the HMO.

* For PE employees: Unless prescription drug coverage is provided through a union Employee Benefit Fund.

Making a Choice

Selecting a health insurance plan is an important and personal decision. Only you know your family's lifestyle, health, budget and benefit preferences. Think about what health care you and your covered dependents might need during the next year. Review the plans, and ask for more information. Here are several questions to consider:

- What is my premium for the health plan?
- What benefits does the plan have for office visits and other medical care? What is my share of the cost?
- What benefits does the plan have for prescription drugs? Will the medicine I take be covered under the plan? What is my share of the cost? What type of formulary does the plan have? Can I use the mail service pharmacy? (If you receive your drug coverage from a union Employee Benefit Fund, ask the fund about your benefits.)
- Does the plan cover special needs? How is durable medical equipment and other supplies covered? Are there any benefit limitations? (If you or one of your dependents has a medical or mental health/ substance use condition requiring specific treatment or other special needs, check on coverage carefully. Do not assume you will have coverage. Ask The Empire Plan program administrators or HMOs about your specific treatment.)
- Are routine office visits and urgent care covered for out-of-area college students, or is only emergency health care covered?
- What benefits are available for a catastrophic illness or injury?
- What choice of providers do I have under the plan? (Ask if the provider or facilities you use are covered.) How would I consult a specialist if I needed one? Would I need a referral?
- How much paperwork is involved in the health plan? Do I have to fill out forms?

Things to Remember

- Gather as much information as possible
- Consider your and your family's unique needs
- Compare the coverage and cost of your options
- Look for a health plan that provides the best balance of cost and benefits for you

How to Use the Choices Benefit Charts, Pages 18 – 43

The Empire Plan and NYSHIP HMOs are summarized in this booklet. The Empire Plan is available to all employees. You may choose an available NYSHIP HMO based on the area in which you live or work. Identify the plans that best serve your needs, and call each plan for details before you choose.

All NYSHIP plans must include a minimum level of benefits (see page 7). For example, The Empire Plan and all NYSHIP HMOs provide a paid-in-full benefit for medically-necessary inpatient hospital care at network hospitals.

Use the charts to compare plans. The charts list out-of-pocket expenses and benefit limitations effective January 1, 2018. Make note of differences in coverage that are important to you and your family. See plan documents for complete information on benefit limitations.

To generate a side-by-side comparison of the benefits provided by each of the NYSHIP plans in your area, use the NYSHIP Plan Comparison tool, available on NYSHIP Online. Go to www.cs.ny.gov/employee-benefits and choose your group and plan, if prompted. From the NYSHIP Online homepage, select Health Benefits & Option Transfer. Click on Rates and Health Plan Choices and then NYSHIP Plan Comparison. Select your group and the counties in which you live and work. Then, check the box next to the plans you want to compare and click on Compare Plans to generate the comparison table.

Note: Most benefits described in this booklet are subject to medical necessity and may involve limitations or exclusions. Please refer to plan documents or call the plans directly for details.

If You Decide to Change Your Option

If you have reviewed the coverage and cost of your options and decide to change your option, submit a completed *Health Insurance Transaction Form* (PS-404) to your HBA or change your option online using MyNYSHIP (if you are an active employee of a New York State agency) before the Option Transfer deadline announced in the rate flyer. **Note:** MyNYSHIP cannot be used to elect the Opt-out Program (see page 15).

The Empire Plan & NYSHIP HMOs: Similarities & Differences

Will I be covered for medically-necessary care I receive away from home?

The Empire Plan:

Yes. The Empire Plan provides worldwide coverage. However, access to **network benefits** is not guaranteed in all states and regions.

NYSHIP HMOs:

Under an HMO, you are always covered for emergency care. Some HMOs may provide coverage for routine care outside the HMO service area. Additionally, some HMOs provide coverage for college students away from home if the care is urgent or if follow-up care has been preauthorized. See the out-of-area benefit description on each HMO page for more information, or contact the HMO directly.

If I am diagnosed with a serious illness, can I see a physician or go to a hospital that specializes in my illness?

The Empire Plan:

Yes. You can use the specialist of your choice. If the doctor you choose participates in The Empire Plan network, benefits will apply for covered services. You have Basic Medical Program benefits for nonparticipating providers and Basic Medical Provider Discount Program benefits for nonparticipating providers who are part of the Empire Plan MultiPlan group (see page 21 for more information on the Basic Medical Provider Discount Program). Your hospital benefits will differ depending on whether you choose a network or non-network hospital (see page 13 for details).

NYSHIP HMOs:

You should expect to choose a participating physician and a participating hospital. Under certain circumstances, you may be able to receive a referral to a specialist care center outside the network.

Can I be sure I will not need to pay more than my copayment when I receive medical services?

The Empire Plan:

Your copayment should be your only expense if you receive medically-necessary and covered services from a participating provider.

NYSHIP HMOs:

As long as you receive medically-necessary and covered services, follow HMO requirements and receive the appropriate referral (if required), your copayment or coinsurance should be your only expense.

Can I use the hospital of my choice?

The Empire Plan:

Yes. You have coverage worldwide, but your benefits differ depending on whether you choose a network or non-network hospital. Your benefits are highest at network hospitals participating in the BlueCross and BlueShield Association BlueCard® PPO Program or for mental health or substance abuse care in the Beacon Health Options network.

Network hospital inpatient: Paid-in-full hospitalization benefits.

Network hospital outpatient and emergency care: Subject to network copayments.

Non-network hospital inpatient stays and outpatient services: 10 percent coinsurance for inpatient stays and the greater of 10 percent coinsurance or $75 for outpatient services, up to the combined annual coinsurance maximum per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined (see page 19).

NYSHIP HMOs:

Except in an emergency, you generally do not have coverage at non-network hospitals unless authorized by the HMO.

What kind of care is available for physical therapy, occupational therapy and chiropractic care?

The Empire Plan:

You have guaranteed access to unlimited, medically-necessary care when you follow Plan requirements.

NYSHIP HMOs:

Coverage is available for a specified number of days/visits each year, as long as you follow the HMO's requirements.

What if I need durable medical equipment, medical supplies or home nursing?

The Empire Plan:

You have guaranteed, paid-in-full access to medically-necessary home care, equipment and supplies[1] through the Home Care Advocacy Program (HCAP) when preauthorized and arranged by the Plan.

NYSHIP HMOs:

Benefits are available and vary depending on the HMO. Benefits may require a greater percentage of cost sharing.

[1] Diabetic shoes have an annual maximum benefit of $500.

Note: These responses are generic and highlight only general differences between The Empire Plan and NYSHIP HMOs. Details for each plan are available on individual plan pages beginning on page 18 of this booklet, in the *Empire Plan Certificate* (available online or from your HBA) and in the HMO contracts (available from each HMO).

Questions & Answers

Q: Can I join The Empire Plan or any NYSHIP-approved HMO?

A: The Empire Plan is available worldwide. To enroll or continue enrollment in a NYSHIP-approved HMO, you must live or work in that HMO's service area. If you move permanently out of and/or no longer work in your HMO's service area, you must change options. See Plans by County on pages 16 and 17 and the individual HMO pages in this booklet to check the counties each HMO will serve in 2018.

Q: How do I find out which providers and hospitals participate? What if my doctor or other provider leaves my plan?

A: Check with your providers directly to see whether they participate in The Empire Plan or in a NYSHIP HMO.

For Empire Plan provider information:

- Use the online provider directories at www.cs.ny.gov/employee-benefits. Select your group and plan, if prompted, and then Find a Provider. **Note:** This is the most up-to-date source for provider information.
- Ask your HBA for The Empire Plan *Participating Provider Directory*. (Always check with a provider to ensure current participation.)
- Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program for the type of provider you need.

For HMO provider information:

- Visit the HMO websites (addresses are provided on the individual HMO pages in this booklet).
- Call the telephone numbers on the HMO pages in this booklet. Ask which providers participate and which hospitals are affiliated.

If you choose a provider who does not participate in your plan, check carefully whether benefits will be available to you and at what level. Ask if you need authorization to have the provider's services covered. In most circumstances, HMOs do not provide benefits for services by nonparticipating providers or hospitals. Under The Empire Plan, you have benefits for participating and nonparticipating providers, although your out-of-pocket costs are higher when you use a nonparticipating provider.

Note: You cannot change your plan outside the Option Transfer Period if your only reason for the change is that your provider no longer participates.

Q: I have a preexisting condition. Will I have coverage if I change options?

A: Yes. Under NYSHIP, you can change your option and still have coverage for a preexisting condition. There are no preexisting condition exclusions in any NYSHIP plan. However, coverage and exclusions differ. Ask the plan you are considering about coverage for your condition.

Q: What if I retire in 2018 and become eligible for Medicare?

A: Regardless of which option you choose, as a retiree, you and your dependent must be enrolled in Medicare Parts A and B when either of you first becomes eligible for primary Medicare coverage (see page 6). Please note that your NYSHIP benefits become secondary to Medicare and that your benefits may change.

Q: I am a COBRA dependent in a Family plan. Can I switch to Individual coverage and select a different health plan than the rest of my family?

A: Yes. As a COBRA dependent, you may elect to change to Individual coverage in a plan different from the enrollee's Family coverage. During the Option Transfer Period, you may enroll in The Empire Plan or choose any NYSHIP-approved HMO in the area where you live or work.

Q: I elected the Opt-out Program in 2017. Can I switch to NYSHIP health coverage for 2018?

A: Yes. All options are available during the Option Transfer Period (see Making a Choice on page 11). However, if you decide to stay in the Opt-out Program, you must reenroll for 2018.

The Opt-Out Program NYSHIP Code #700

The Opt-out Program is available to eligible employees who have other employer-sponsored group health benefits. If eligible, you may opt out of NYSHIP coverage in exchange for an incentive payment. **Note:** The State Opt-out Program is not available to employees of PEs; however, a PE may offer a similar option.

The annual incentive payment is $1,000 for opting out of Individual coverage or $3,000 for opting out of Family coverage. The incentive payment is prorated and credited in your biweekly paycheck throughout the year (payable only when you are eligible for NYSHIP coverage at the employee share of the premium). **Note:** Opt-out incentive payments increase your taxable income.

Enrollment in the Opt-out Program does not continue automatically from year to year. To be eligible for the incentive payments, you must enroll during each Option Transfer Period and attest to having other coverage for the coming plan year.

Eligibility Requirements

To be eligible for the Opt-out Program, you must:

- Have been enrolled in the Opt-out Program for the prior plan year or enrolled in a NYSHIP health plan by April 1, 2017, (or on your first date of NYSHIP eligibility if that date is later than April 1) and
- Remain continuously enrolled while eligible for the employee share of the premium through the end of 2017.

To qualify for the Opt-out Program, you must be covered under an employer-sponsored group health insurance plan through other employment of your own or a plan that your spouse, domestic partner or parent has as the result of his or her employment. New York State employees cannot opt out of NYSHIP if they are covered under NYSHIP as a dependent through another NYS employee.

According to NYSHIP rules, an individual cannot be enrolled in two NYSHIP options in his or her own right. Since the Opt-out Program is considered a NYSHIP option, an individual cannot opt out through one employer and be enrolled in NYSHIP health benefits in his or her own right through another employer.

If the employee is covered as a dependent on another NYSHIP policy through a local government or public entity, he or she is only eligible for the Individual Opt-out incentive amount ($1,000).

Make sure the other employer-sponsored plan will permit you to enroll as a dependent. You are responsible for making sure your other coverage is in effect during the period you opt out of NYSHIP.

Note: Opt-out Program participation satisfies NYSHIP enrollment requirements at the time of your retirement. The Opt-out Program is not available to retirees.

Electing to Opt Out

If you are currently enrolled in NYSHIP and wish to participate in the Opt-out Program, you must elect to opt out during the annual Option Transfer Period and attest to and provide information regarding your other employer-sponsored group health benefits for the next plan year.

To elect the Opt-out Program, you must submit a completed and signed *NYS Health Insurance Transaction Form* (PS-404) and an *Opt-out Attestation Form* (PS-409) to your HBA. Your NYSHIP coverage will terminate at the end of the plan year, and the incentive payments will begin with the first pay period affecting coverage for 2018.

Once enrolled in the Opt-out Program, you are not eligible for the incentive payment during any period that you do not meet the requirements for the State contribution to the cost of your NYSHIP coverage. Additionally, if you are receiving the opt-out incentive for Family coverage and your last dependent loses NYSHIP eligibility, you will only be eligible for the Individual payment from that date forward.

Reminder: All options are available to you during the Option Transfer Period. If you are currently enrolled in the Opt-out Program, you may choose other NYSHIP coverage or elect to opt out again for 2018.

Plans by County

The Empire Plan

The Empire Plan is available to all enrollees in the New York State Health Insurance Program (NYSHIP). You may choose The Empire Plan regardless of where you live or work. Coverage is worldwide. See pages 18-27 for a summary of The Empire Plan.

Health Maintenance Organizations (HMOs)

Most NYSHIP enrollees have a choice among HMOs. You may enroll or continue to be enrolled in any NYSHIP-approved HMO that serves the area where you live or work. You may not be enrolled in an HMO outside your area. This list will help you determine which HMOs are available by county.

Albany: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)	**Erie:** BCBS of Western New York* (067), Independent Health* (059)
Allegany: BCBS of Western New York* (067), Independent Health* (059)	**Essex:** CDPHP* (300), EBCBS HMO* (280), HMOBlue (160), MVP (360)
Bronx: EBCBS HMO* (290), HIP* (050)	**Franklin:** HMOBlue (160), MVP (360)
Broome: CDPHP* (300), HMOBlue* (072), MVP* (330)	**Fulton:** CDPHP* (063), EBCBS HMO* (280), HMOBlue (160), MVP* (060)
Cattaraugus: BCBS of Western New York* (067), Independent Health* (059)	**Genesee:** BCBS of Western New York* (067), Independent Health* (059), MVP* (058)
Cayuga: HMOBlue* (072), MVP* (330)	**Greene:** CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)
Chautauqua: BCBS of Western New York* (067), Independent Health* (059)	**Hamilton:** CDPHP* (300), HMOBlue (160), MVP* (060)
Chemung: HMOBlue* (072)	**Herkimer:** CDPHP* (300), HMOBlue (160), MVP* (330)
Chenango: CDPHP* (300), HMOBlue (160), MVP* (330)	**Jefferson:** HMOBlue (160), MVP* (330)
Clinton: EBCBS HMO* (280), HMOBlue (160), MVP (360)	**Kings:** EBCBS HMO* (290), HIP* (050)
Columbia: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)	**Lewis:** HMOBlue (160), MVP* (330)
Cortland: HMOBlue* (072), MVP* (330)	**Livingston:** BlueChoice* (066), MVP* (058)
Delaware: CDPHP* (310), EBCBS HMO* (280), HIP (350), HMOBlue (160), MVP* (330)	**Madison:** CDPHP* (300), HMOBlue (160), MVP* (330)
Dutchess: CDPHP* (310), EBCBS HMO* (320), HIP (350), MVP* (340)	**Monroe:** BlueChoice* (066), MVP* (058)

* Medicare-primary NYSHIP enrollees will be enrolled in this HMO's Medicare Advantage Plan. For more information about NYSHIP Medicare Advantage Plans, ask your HBA for a copy of *2018 Choices* for Retirees.

Montgomery: CDPHP* (063), EBCBS HMO* (280), HMOBlue (160), MVP* (060)

Nassau: EBCBS HMO* (290), HIP* (050)

New York: EBCBS HMO* (290), HIP* (050)

Niagara: BCBS of Western New York* (067), Independent Health* (059)

Oneida: CDPHP* (300), HMOBlue (160), MVP* (330)

Onondaga: HMOBlue* (072), MVP* (330)

Ontario: Blue Choice* (066), MVP* (058)

Orange: CDPHP* (310), EBCBS HMO* (320), HIP (350), MVP* (340)

Orleans: BCBS of Western New York* (067), Independent Health* (059), MVP* (058)

Oswego: HMOBlue* (072), MVP* (330)

Otsego: CDPHP* (300), HMOBlue (160), MVP* (330)

Putnam: EBCBS HMO* (320), HIP (350), MVP* (340)

Queens: EBCBS HMO* (290), HIP* (050)

Rensselaer: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)

Richmond: EBCBS HMO* (290), HIP* (050)

Rockland: EBCBS HMO* (290), MVP* (340)

Saratoga: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)

Schenectady: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)

Schoharie: CDPHP* (063), EBCBS HMO* (280), MVP* (060)

Schuyler: HMOBlue* (072)

Seneca: Blue Choice* (066), MVP* (058)

St. Lawrence: HMOBlue (160), MVP (360)

Steuben: HMOBlue* (072), MVP* (058)

Suffolk: EBCBS HMO* (290), HIP* (050)

Sullivan: EBCBS HMO* (320), HIP (350), MVP* (340)

Tioga: CDPHP* (300), HMOBlue* (072), MVP* (330)

Tompkins: HMOBlue* (072), MVP* (330)

Ulster: CDPHP* (310), EBCBS HMO* (320), HIP (350), MVP* (340)

Warren: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)

Washington: CDPHP* (063), EBCBS HMO* (280), HIP (220), MVP* (060)

Wayne: Blue Choice* (066), MVP* (058)

Westchester: EBCBS HMO* (290), HIP* (050), MVP* (340)

Wyoming: BCBS of Western New York* (067), Independent Health* (059), MVP* (058)

Yates: Blue Choice* (066), MVP* (058)

* Medicare-primary NYSHIP enrollees will be enrolled in this HMO's Medicare Advantage Plan. For more information about NYSHIP Medicare Advantage Plans, ask your HBA for a copy of *2018 Choices* for Retirees.

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, 2018.[1] You may also visit 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 $20 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 20) 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 21).

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/Reports* for details).

Managed Physical Medicine Program – Chiropractic treatment, physical therapy and occupational therapy through a Managed Physical Network (MPN) provider are subject to a $20 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

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

covered services received from a non-network provider will be paid in accordance with the Basic Medical portion of the Medical/Surgical Program

If you are an Empire Plan-primary enrollee[2], 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, per all enrolled dependent children combined (see page 21).

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 $20 copayment per visit applies)
- Outpatient services, including office visits, home-based or telephone counseling and nurse practitioner services ($20 copayment)
- Outpatient rehabilitation with an approved structured outpatient rehabilitation program for substance use ($20 copayment)

Non-Network Benefits[3]

(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, per all enrolled dependent children combined. After the combined annual coinsurance maximum is reached per enrollee per enrolled spouse or domestic partner, per all enrolled dependent children combined, the

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

[3] You are responsible for ensuring that MHSA Program certification is received for care obtained from a non-network practitioner or facility.

Program pays up to 100 percent of usual and customary charges for covered services (see page 21).
- 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, 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 21).
- Outpatient treatment sessions for family members of an alcoholic, alcohol abuser or substance abuser 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 with 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 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.

2018 Annual Maximum Out-of-Pocket Limit

Your maximum out-of-pocket expenses for in-network covered services will be $4,800 for Individual coverage and $9,600 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 $1,000 per enrollee, $1,000 per enrolled spouse/domestic partner and $1,000 per 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.

The $1,000 combined annual deductible amount will be reduced to $500 per calendar year for employees in or equated to Salary Grade 6 or below on January 1, 2018. **Note:** This reduction is not available to judges and justices or employees of PEs.

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 and 10 percent for non-network MHSA-approved facility services.

Combined Annual Coinsurance Maximum

The Empire Plan has a combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per enrolled spouse/domestic partner and $3,000 per 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 $3,000 combined annual coinsurance maximum will be reduced to $1,500 per calendar year for employees in or equated to Salary Grade 6 or below. **Note:** This reduction is not available to judges and justices or employees of PEs.

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/Reports* and *Reporting On Center of Excellence Programs* available at 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. 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.
- For certain maintenance medications, you are required to fill at least two 30-day supplies using your Empire Plan Prescription Drug Program benefits before a supply for greater than 30 days will be covered. If you attempt to fill a prescription for a maintenance medication for more than a 30-day supply at a network or mail service pharmacy, the last 180 days of your prescription history will be reviewed to determine whether at least 60 days’ worth of the drug was previously dispensed. If not, only a 30-day fill will be approved. This program is referred to as the New to You Prescriptions Program.
- 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 fill out 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.

2018 Annual Maximum Out-Of-Pocket Limit*

Your annual maximum out-of-pocket expenses for covered drugs received from a network pharmacy will be $2,550 for Individual coverage and $5,100 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 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, to request refills or to 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 2018, ask your HBA for a copy of *2018 Choices* for Retirees for information about your coverage under Empire Plan Medicare Rx, a Medicare Part D prescription drug program.

The Empire Plan NurseLine℠

Call The Empire Plan and press or say 5 for the NurseLine℠ 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

For callers who use a TTY device because of a hearing or speech disability. All TTY numbers are 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 employees of the State of New York, Participating Employers, their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees.

Benefits	Network Hospital Benefits[1,2]	Participating Provider[2]	Nonparticipating Provider
Office Visits[2]		$20 per visit	Basic Medical[3]
Specialty Office Visits[2]		$20 per visit	Basic Medical[3]
Diagnostic Services:[2]			
Radiology	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Lab Tests	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Pathology	No copayment	$20 per visit	Basic Medical[3]
EKG/EEG	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Radiation, Chemotherapy, Dialysis	No copayment	No copayment	Basic Medical[3]
Women's Health Care/OB GYN:[2]			
Screenings and Maternity-Related Lab Tests	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Mammograms	No copayment	No copayment	Basic Medical[3]
Pre/Postnatal Visits and Well-Woman Exams		$20 per visit	Basic Medical[3]
Bone Density Tests[2]	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Breastfeeding Services and Equipment		No copayment for pre/postnatal counseling and equipment purchase from a participating provider; one double-electric breast pump per birth	
Family Planning Services[2]		$20 per visit	Basic Medical[3]
Infertility Services[5]	$30[4] or $40 per outpatient visit	$20 per visit; no copayment at designated Centers of Excellence[5]	Basic Medical[3]
Contraceptive Drugs and Devices		No copayment for certain FDA-approved oral contraception methods (including outpatient surgical implantation) and counseling	Basic Medical[3]

Benefits	Network Hospital Benefits[1,2]	Participating Provider[2]	Nonparticipating Provider
Inpatient Hospital Surgery	No copayment[6]	No copayment	Basic Medical[3]
Outpatient Surgery	$40[4] or $60 per visit	$20 per visit[7]	Basic Medical[3]
Emergency Room	$60[4] or $70 per visit[8]	No copayment	Basic Medical[3,9]
Urgent Care	$30[4] or $40 per outpatient visit[10]	$20 per visit	Basic Medical[3]
Ambulance	No copayment[11]	$35 per trip[12]	$35 per trip[12]
Mental Health Practitioner Services		$20 per visit	Applicable annual deductible,[3] 80% of usual and customary; after applicable coinsurance max,[3] 100% of usual and customary (see pages 20-21 for details)
Approved Facility Mental Health Services		No copayment	90% of billed charges; after applicable coinsurance max,[3] covered in full (see pages 20-21 for details)
Outpatient Drug/ Alcohol Rehabilitation		$20 per visit to approved Structured Outpatient Rehabilitation Program	Applicable annual deductible,[3] 80% of usual and customary; after applicable coinsurance max,[3] 100% of usual and customary (see pages 20-21 for details)

1 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 21).

2 Copayment waived for preventive services under PPACA. See www.hhs.gov/healthcare/rights/preventive-care or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

3 See Cost Sharing (beginning on page 20) for Basic Medical information.

4 Copayment for CSEA and UCS enrollees only.

5 Certain qualified procedures require precertification and are subject to a $50,000 lifetime allowance.

6 Preadmission certification required.

7 In outpatient surgical locations (Medical/Surgical Program), the copayment for the facility charge is $30 per visit or Basic Medical benefits apply, depending upon the status of the center. (Check with the center or The Empire Plan program administrators.)

8 Copayment waived if admitted.

9 Attending emergency room 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.

10 At a hospital-owned urgent care facility only.

11 If service is provided by admitting hospital.

12 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[1,2]	Participating Provider[2]	Nonparticipating Provider
Inpatient Drug/ Alcohol Rehabilitation		No copayment	90% of billed charges; after applicable coinsurance max,[3] covered in full (see pages 20-21 for details)
Durable Medical Equipment		No copayment (HCAP)	50% of network allowance (see the *Empire Plan Certificate/Reports*)
Prosthetics		No copayment[13]	Basic Medical[3,13] $1,500 lifetime maximum benefit for prosthetic wigs not subject to deductible or coinsurance
Orthotic Devices		No copayment[13]	Basic Medical[3,13]
External Mastectomy Prostheses		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[3,13]
Rehabilitative Care (not covered in a skilled nursing facility if Medicare primary)	No copayment as an inpatient; $20 per visit for outpatient physical therapy following related surgery or hospitalization[14]	Physical or occupational therapy $20 per visit (MPN) Speech therapy $20 per visit	$250 annual deductible, 50% of network allowance Basic Medical[3]
Diabetic Supplies		No copayment (HCAP)	50% of network allowance (see the *Empire Plan Certificate/Reports*)
Insulin and Oral Agents (covered under the Prescription Drug Program, subject to drug copayment)			
Diabetic Shoes		$500 annual maximum benefit	75% of network allowance up to an annual maximum benefit of $500 (see the *Empire Plan Certificate/Reports*)
Hospice	No copayment, no limit		10% of billed charges up to the combined annual coinsurance maximum
Skilled Nursing Facility (not covered if Medicare Primary)	No copayment up to 365 benefit days[15]		

Benefits	Network Hospital Benefits[1,2]	Participating Provider[2]	Nonparticipating Provider
Prescription Drugs (see pages 22-23)			
Specialty Drugs (see pages 22-23)			
Additional Benefits			
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: $2,550 for the Prescription Drug Program.[16] $4,800 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Abuse Programs Family coverage: $5,100 for the Prescription Drug Program.[16] $9,600 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℠ 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 *Empire Plan Preventive Care Coverage Chart* on NYSHIP Online under Publications. Or, visit www.hhs.gov/healthcare/rights/preventive-care.			

1 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 21).

2 Copayment waived for preventive services under PPACA. See www.hhs.gov/healthcare/rights/preventive-care or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

3 See Cost Sharing (beginning on page 20) for Basic Medical information.

13 Benefit paid up to cost of device meeting individual's functional need.

14 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.

15 Precertification required.

16 Does not apply to Medicare-primary enrollees.

Blue Choice
A product of Excellus BlueCross BlueShield, Rochester Region

Benefits	Enrollee Cost
Office Visits	$25 per visit ($5 for children to age 26)
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$40 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	$25 per visit
Chemotherapy	$25 for Rx injection and $25 office copayment (max two copayments per day)
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment (routine), $40 copayment (diagnostic)
Family Planning Services	$25 PCP, $40 specialist per visit
Infertility Services	Applicable physician/ facility copayment
Contraceptive Drugs	Applicable Rx copayment[1]
Contraceptive Devices	Applicable copayment/ coinsurance[1]
Inpatient Hospital Surgery	
Physician	No copayment
Facility	No copayment

Benefits	Enrollee Cost
Outpatient Surgery	
Hospital	$50 per visit
Physician's Office	$50 copayment or 20% coinsurance, whichever is less
Outpatient Surgery Facility	$40 physician and $50 facility per visit
Emergency Room (waived if admitted within 24 hours)	$100 per visit
Urgent Care Facility	$35 per visit
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$40 per visit
Group, unlimited	$40 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Physical or Occupational Therapy, max 30 visits for all outpatient services combined	$40 per visit
Outpatient Speech Therapy, max 30 visits for all outpatient services combined	$40 per visit
Diabetic Supplies up to a 30-day supply	$25 per item
Insulin and Oral Agents up to a 30-day supply	$25 per prescription
Diabetic Shoes one pair per year when medically necessary	50% coinsurance

[1] Generic oral contraceptives and certain OTC contraceptive devices are covered in full in accordance with the Affordable Care Act.

Benefits	Enrollee Cost
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days per admission, 360-day lifetime max	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1, $30 Tier 2, $50 Tier 3[2]
Mail Order, up to 90-day supply	$20 Tier 1, $60 Tier 2, $100 Tier 3[2]
You can purchase a 90-day supply of a maintenance medication at a retail pharmacy for a $30, $90 or $150 copayment. You are limited to a 30-day supply for the first fill. Coverage includes fertility drugs, injectable and self-injectable medications and enteral formulas.	
Specialty Drugs Designated specialty drugs are covered only at a network specialty pharmacy, subject to the same days' supply and cost-sharing requirements as the retail benefit, and cannot be filled via mail order. A current list of specialty medications and pharmacies is available at www.excellusbcbs.com.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) .... $6,350 Individual, $12,700 Family per year

Dental[3] .... $40 per visit

Vision[4] .... $40 per visit

Hearing Aids .... Children to age 19: Covered in full for up to two hearing aids every three years

Out of Area .... Our BlueCard and Away From Home Care Programs cover routine and urgent care while traveling, for students away at school, members on extended out-of-town business and for families living apart

Maternity
(Physician's charge for delivery) .... $50 copayment

Plan Highlights for 2018

Laboratory and pathology services are covered in full. We deliver high-quality coverage, plus discounts on services that encourage you to keep a healthy lifestyle.

Participating Physicians

With more than 3,200 providers available, Blue Choice offers you more choice of doctors than any other area HMO. Talk to your doctor about whether Blue Choice is the right plan for you.

Affiliated Hospitals

All operating hospitals in the Blue Choice service area are available to you, plus some outside the service area. Please call the number provided for a directory, or visit www.excellusbcbs.com.

Pharmacies and Prescriptions

Fill prescriptions at any of our more than 60,000 participating pharmacies nationwide. Simply show the pharmacist your ID card. Blue Choice offers convenient mail order services for select maintenance drugs. Blue Choice offers an **incented formulary**.

Medicare Coverage

Medicare-primary NYSHIP enrollees must enroll in Medicare Blue Choice, our **Medicare Advantage Plan**. To qualify, you must be enrolled in Medicare Parts A and B and live in the service area. Some copayments will vary.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Please be sure to check before receiving care that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 066

A Network HMO serving individuals living or working in the following counties: Livingston, Monroe, Ontario, Seneca, Wayne and Yates.

Blue Choice

165 Court Street, Rochester, NY 14647

For Information:

Blue Choice: 1-800-499-1275

TTY: 1-800-421-1220

Medicare Blue Choice: 1-877-883-9577

Website: www.excellusbcbs.com

[2] If your doctor prescribes a brand-name drug when an FDA-approved generic equivalent is available, you pay the difference between the cost of the generic and the brand-name drug, plus any applicable copayments.

[3] Coverage for accidental injury to sound and natural teeth and for care due to congenital disease or anomaly; routine care not covered.

[4] Coverage for exams to treat a disease or injury; routine care not covered.

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit
Lab Tests	No copayment[1]
Pathology	No copayment
EKG/EEG	$20 per visit
Radiation	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	$20 for initial visit only[2]
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$20 per visit
Infertility Services[3]	$20 per visit
Contraceptive Drugs	No copayment[4]
Contraceptive Devices	No copayment[4]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$100 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$100 per visit
Emergency Room (waived if admitted)	$100 per visit

Benefits	Enrollee Cost
Urgent Care Facility[5]	$35 per visit
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	20% coinsurance
Orthotics	20% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient Physical or Occupational Therapy, max 20 visits[6]	$20 per visit
Outpatient Speech Therapy, max 20 visits[6]	$20 per visit
Diabetic Supplies	$20 per item
Insulin and Oral Agents	$20 per item
Diabetic Shoes	Not covered
Hospice, max 210 days per year	No copayment

[1] For services at a standalone Quest lab or outpatient hospital that participates as a Quest Diagnostics hospital draw site. Lab services performed in conjunction with outpatient surgery or an emergency room visit also paid in full.

[2] One-time $20 copayment to confirm pregnancy. No copayment for inpatient maternity care or gestational diabetes screenings.

[3] For services to diagnose and treat infertility. See "Additional Benefits" for artificial insemination.

[4] No copayment for contraceptive drugs and devices unless a generic equivalent is available, in which case you are subject to a $30 (Tier 2) or $60 (Tier 3) copayment. A mail-order supply costs 2.5 times the applicable copayment.

[5] Urgent Care is only covered in our eight-county service area of Western New York.

[6] Twenty visits in aggregate for physical therapy, occupational therapy and speech therapy.

Benefits	Enrollee Cost
Skilled Nursing Facility max 50 days	No copayment
Prescription Drugs	
Retail, 30-day supply[4]	$5 Tier 1, $30 Tier 2, $60 Tier 3
Mail Order, 90-day supply	$12.50 Tier 1, $75 Tier 2, $150 Tier 3
Includes prenatal vitamins, fertility drugs, injectable/self-injectable medications, insulin and oral diabetic agents. May require prior approval.	
Specialty Drugs Available through mail order at the applicable copayment.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits)........$3,000 Individual, $6,000 Family per year

Dental........Not covered

Vision[7]........Discounts available

Hearing Aids[8]........Discounts available

Out of Area........Worldwide coverage for emergency care through the BlueCard Program. Away From Home Care (AFHC) allows you to obtain coverage through a nearby Blue HMO when you are away from home and our service area.

Artificial Insemination........20% coinsurance
Other artificial means to induce pregnancy (in-vitro embryo transfer, etc.) are not covered

Wellness Services........$300 Wellness Card allowance for use at participating facilities

Plan Highlights for 2018

Wellness allowance may be used for, but not limited to, acupuncture, massage therapy, chiropractic visits, and health food stores. Visit www.bcbswny.com for information on discounts and wellness programs.

Participating Physicians

You have access to 7,000+ physicians/healthcare professionals.

Affiliated Hospitals

You may receive care at all Western New York hospitals and other hospitals if medically necessary.

Pharmacies and Prescriptions

Our network includes 45,000 participating pharmacies. Prescriptions filled up to 30-day supply. BlueCross BlueShield offers an **incented formulary**.

Medicare Coverage

Medicare-primary enrollees are required to enroll in Senior Blue HMO, our **Medicare Advantage Plan**. To qualify, you must enroll in Medicare Parts A & B and live in one of the counties below.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Please be sure to check before receiving care that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 067

An IPA HMO serving individuals living or working in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

BlueCross BlueShield of Western New York

P.O. Box 80, Buffalo, NY 14240-0080

For Information:

BlueCross BlueShield of Western New York:
716-887-8840 or 1-877-576-6440

TTY: 711

Website: www.bcbswny.com/NYSHIP

[7] Call 1-888-497-7419 for discount information.
[8] Call 1-800-334-1807 for discount information.

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology[1]	$20 per visit
Lab Tests[2]	$10 per visit
Pathology	$10 per visit
EKG/EEG	$20 per visit
Radiation[1]	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services[3]	$20 per visit
Infertility Services	
Physician Office	$20 per visit
Outpatient Surgery Facility	$100 per visit
Contraceptive Drugs	Applicable Rx copayment[4]
Contraceptive Devices	Applicable Rx copayment[4]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$100 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$100 per visit
Emergency Room (waived if admitted within 24 hours)	$100 per visit

Benefits	Enrollee Cost
Urgent Care Facility	$35 per visit[5]
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	No copayment
Orthotics[6]	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient Physical or Occupational Therapy, max 20 visits per year for all outpatient services combined	$20 per visit
Outpatient Speech Therapy, max 20 visits per year for all outpatient services combined	$20 per visit
Diabetic Supplies	
Retail, 90-day supply	$20 per item
Mail Order	Not available
Insulin and Oral Agents	$20 per item or applicable Rx copayment, whichever is less
Diabetic Shoes one pair per year when medically necessary	No copayment

[1] Office based: $20 copayment; hospital based: $40 copayment

[2] No copayment for lab tests drawn and processed in a primary care or specialist setting.

[3] Only preventive family planning services are covered in full. Non-preventive services require a copayment.

[4] Copayment applies only for select Tier 3 oral contraceptive drugs and devices.

[5] Within the service area. Outside the service area: $20 copayment, plus the difference in cost between Independent Health's payment and the provider's charges, if any. $35 per visit to a participating After-Hours Care Facility.

[6] Excludes shoe inserts.

Benefits	Enrollee Cost
Hospice, unlimited	No copayment
Skilled Nursing Facility max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 Tier 1, $30 Tier 2, $60 Tier 3
Mail Order, 90-day supply	$12.50 Tier 1, $75.00 Tier 2, $150 Tier 3
Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas.	
Specialty Drugs Benefits are provided for specialty drugs by two contracted specialty pharmacy vendors, Reliance Rx Pharmacy and Walgreens Specialty Pharmacy. Specialty drugs, available through the prescription drug benefit, include select high-cost injectables and oral agents such as oral oncology drugs. Specialty drugs require prior approval and are subject to the applicable Rx copayment based on the formulary status of the medication. Members pay one copayment for each 30-day supply.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits)........$4,000 Individual, $8,000 Family per year

Dental........$50 per cleaning and 20% discount on additional services at select providers (preventive only)

Vision........$10 per visit once every 12 months (routine only)

Hearing Aids........Discounts available at select locations

Out of Area........While traveling outside the service area, members are covered for emergency and urgent care situations only

Home Health Care, max 40 visits........$20 per visit

Eyeglasses........$50 for single vision lenses, frames; 40% off retail price

Urgent Care in Service Area for After-Hours Care........$35 per visit[7]

Wellness Services........$275 allowance for use at a participating facility

Plan Highlights for 2018

Independent Health has led the way in providing Western New York with innovative solutions that set the standard for quality and service for health plans. We've consistently earned top ratings from NCQA, which is why you can feel comfortable and confident choosing us for your health coverage needs.

Participating Physicians

Independent Health is affiliated with more than 4,000 physicians and health care providers throughout the eight counties of Western New York.

Affiliated Hospitals

Independent Health members are covered at all western New York hospitals and may be directed to other hospitals when medically necessary.

Pharmacies and Prescriptions

All retail pharmacies in western New York participate. Members may obtain prescriptions out of the service area by using our National Pharmacy Network, which includes 58,000 pharmacies nationwide. Independent Health offers a **closed formulary**.

Medicare Coverage

Medicare-primary NYSHIP retirees must enroll in Medicare Encompass, a **Medicare Advantage Plan**. Copayments differ from the copayments of a NYSHIP-primary enrollee. Call for detailed information.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Please be sure to check before receiving care that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 059

An IPA HMO serving individuals living or working in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Independent Health

511 Farber Lakes Drive, Buffalo, NY 14221

For Information:

Customer Service: 1-800-501-3439
TTY: 716-631-3108
Website: www.independenthealth.com

[7] $35 copayment for brick-and-mortar freestanding urgent care centers (WNY Immediate Care, MASH Urgent Care, etc.). $20 copayment is for urgent care provided in a participating primary care physician's office.

Benefits	Enrollee Cost
Office Visits	$25 per visit ($10 for children)[1]
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$25 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$25 per visit
Radiation	$40 per visit
Chemotherapy	$40 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services[2]	$25 PCP, $40 specialist per visit
Infertility Services[2]	$25 PCP, $40 specialist per visit
Contraceptive Drugs[3]	No copayment[4]
Contraceptive Devices[3]	No copayment[4]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$40 per visit
Physician's Office	$25 PCP, $40 specialist per visit
Outpatient Surgery Facility	$40 per visit
Emergency Room (waived if admitted)	$75 per visit
Ambulance	$50 per trip

Benefits	Enrollee Cost
Outpatient Mental Health	
Individual, unlimited	$25 per visit
Group, unlimited	$25 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics[5]	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 2 months per condition	No copayment
Outpatient Physical or Occupational Therapy, max 30 visits for all outpatient services combined	$40 per visit
Outpatient Speech Therapy, max 30 visits for all outpatient services combined	$40 per visit
Diabetic Supplies 31-day supply	$25 per boxed item
Insulin and Oral Agents 31-day supply	$25 per boxed item
Diabetic Shoes unlimited pairs when medically necessary	50% coinsurance
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days/calendar year	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1, $30 Tier 2, $50 Tier 3

[1] PCP sick visits for children (newborn up to age 26) $10 per visit.

[2] Please refer to the *Certificate Of Coverage* for language regarding Infertility Services.

[3] Over-the-counter contraceptives are not covered.

[4] Brand-name contraceptives with generic equivalents require member payment of the difference in cost between the generic and brand-name drugs, plus the Tier 1 copayment.

[5] External breast prosthetic has a 20% coinsurance.

Benefits	Enrollee Cost
Prescription Drugs, *continued*	
Mail Order, 90-day supply	$25 Tier 1, $75 Tier 2, $125 Tier 3

If a member requests a brand-name drug to the prescribed generic drug, he/she pays the difference between the cost of the generic and the brand-name drug, plus the Tier 1 copayment. Coverage includes fertility, injectable and self-injectable medications and enteral formulas. Approved generic contraceptive prescription drugs and devices and those without a generic equivalent are covered at 100% under retail and mail order.

Specialty Drugs

MVP uses CVS Caremark for specialty pharmacy services. Copayments are listed under the Prescription Drug benefit.

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits)........$6,350 Individual, $12,700 Family per year

Dental........$25 per preventive visit (children to age 19)

Vision........$25 per exam every 24 months (routine only)

Hearing Aids........Not covered

Out of Area........While traveling outside the service area, coverage is provided for emergency situations only

Plan Highlights for 2018

Each MVP subscriber receives $100 HealthDollars to spend on health, wellness and fitness programs. No referrals required. As an MVP member, you can enjoy significant savings on a wide variety of health-related items, plus special discounts on LASIK eye surgery, eyewear and alternative medicine.

Participating Physicians

MVP Health Care provides services through more than 28,500 participating physicians and health practitioners located throughout its service area.

Affiliated Hospitals

MVP members are covered at participating area hospitals to which their MVP physician has admitting privileges. MVP members may be directed to other hospitals to meet special needs when medically necessary upon prior approval from MVP.

Pharmacies and Prescriptions

Virtually all pharmacy “chain” stores and many independent pharmacies within the MVP service area participate with MVP. Also, MVP offers convenient mail-order service for select maintenance drugs. MVP offers an **incented formulary**.

Medicare Coverage

Medicare-primary NYSHIP enrollees must enroll in the MVP Gold Plan, MVP Health Care’s **Medicare Advantage Plan**. Some of the MVP Gold Plan’s copayments may vary from the MVP HMO plan’s copayments. The MVP HMO plan **coordinates coverage** with Medicare in the North Region (360). Please contact Member Services for further details.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO’s network within NYSHIP. Please be sure to check before receiving care that your provider participates with this HMO’s NYSHIP network.

NYSHIP Code Number 058

An IPA HMO serving individuals living or working in the following counties: Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates.

NYSHIP Code Number 060

An IPA HMO serving individuals living or working in the following counties: Albany, Columbia, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

NYSHIP Code Number 330

An IPA HMO serving individuals living or working in the following counties: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins.

NYSHIP Code Number 340

An IPA HMO serving individuals living or working in the following counties: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester.

NYSHIP Code Number 360

An IPA HMO serving individuals living or working in the following counties: Clinton, Essex, Franklin and St. Lawrence.

MVP Health Care

P.O. Box 2207, 625 State Street
Schenectady, NY 12301-2207

For Information:

Customer Service: 1-888-MVP-MBRS (687-6277)

TTY: 1-800-662-1220

Website: www.mvphealthcare.com

NYSHIP Online

NYSHIP Online is designed to provide you with targeted information about your NYSHIP benefits. Visit the New York State Department of Civil Service website at www.cs.ny.gov/employee-benefits and select your group and plan, if prompted.

Ask your HBA for a copy of the NYSHIP Online flyer, which provides helpful navigation information.

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Reminder: If you are an active employee of New York State and a registered user of MyNYSHIP, you may change your option online (excluding the Opt-out Program) during the Option Transfer Period. See your HBA if you have questions.

How to Find Answers to Your Benefit Questions and Gain Access to Additional Important Information

- If you are an active employee, contact your HBA (usually located in your agency's Personnel Office or the Business Services Center).
- If you have questions regarding health insurance claims for The Empire Plan, call 1-877-7-NYSHIP (1-877-769-7447) toll free and choose the appropriate program on the main menu. HMO enrollees should contact their HMOs directly.
- A comprehensive list of contact information for HBAs, HMOs, government agencies, Medicare and other important resources is available on NYSHIP Online in the Using Your Benefits section.

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Using Your Benefits

Empire Plan Copayments

Empire Plan Programs and Administrators Contact Info

Telephone Numbers - General contact information for health and other benefits, benefit funds, and State and U.S. government.

Publications - A library of recent publications related to your benefits.

Empire Plan Providers, Pharmacies and Services

Forms - Empire Plan Claims Forms and Non-Participating Provider Claims Forms and Administrative Forms.

2017 Empire Plan Flexible Formulary

Drugs that Require Prior Authorization

Specialty Pharmacy Drug List

Excluded Drug List

2017 At A Glance - Easy to access benefits summary that can answer most of your general questions

2017 Empire Plan Preventive Care Coverage

Archived Publications

Health Benefits Administrators

Young Adult Option Coverage

Format Options for Forms and Publications

Military Leave Benefit Extension for Employees of the State of New York

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New York State
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
www.cs.ny.gov

NYSHIP
New York State
Health Insurance Program

2018 Health Insurance Choices (Actives) –
October 2017

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. COBRA and Young Adult Option enrollees, contact the Employee Benefits Division.

Health Insurance Choices was printed using recycled paper and environmentally sensitive inks. Choices 2018/Actives AL1499

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.