NYSHIP
New York State Health Insurance Program

2010 NYSHIP Benefit Plan Comparison

Program Component	THE EXCELSIOR PLAN — AN EMPIRE PLAN OPTION		THE EMPIRE PLAN	
Hospital Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**
Covered Inpatient Services *Preadmission Certification Required*	$250 deductible per stay for enrollee, $250 per stay for spouse/domestic partner, and $250 per stay for all dependent children combined (maximum of four deductibles per year for each) Paid-in-full after deductible.	No coverage in a non-network hospital except network benefits apply in the event of an emergency or when there is no network hospital available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.	Paid-in-full	Coinsurance of 10 percent of billed charges up to combined annual inpatient/outpatient maximum of $1,500 for enrollee, $1,500 for spouse/domestic partner, and $1,500 for all dependent children combined. Coinsurance maximums apply as follows: Enrollee pays the first $500, UnitedHealthcare reimburses the enrollee the next $500 of coinsurance (upon written request from enrollee), then the enrollee pays the final $500 of coinsurance.
Skilled Nursing Facility Care (No coverage if Medicare Primary)	Paid-in-full in an approved facility when medically necessary		Paid-in-full in an approved facility when medically necessary	
Hospice Care	Paid-in-full when provided by an approved network program		Paid-in-full when provided by an approved network program	
Outpatient chemotherapy, radiation therapy, dialysis, preadmission testing	Paid-in-full		Paid-in-full	
Covered Outpatient Services (diagnostic radiology/laboratory)	$75 copayment per visit		$40 copayment per visit	Coinsurance of 10 percent of billed charges or $75 (whichever is greater) up to combined annual inpatient/outpatient maximum of $1,500 for enrollee, $1,500 for spouse/domestic partner, and $1,500 for all dependent children combined. Coinsurance maximums apply as follows: Enrollee pays the first $500, UnitedHealthcare reimburses the enrollee the next $500 of coinsurance (upon written request from enrollee), then the enrollee pays the final $500 of coinsurance.
Covered Outpatient Surgery	$100 copayment per visit		$60 copayment per visit	
Physical Therapy Following Related Hospitalization or Inpatient/Outpatient Surgery	$30 copayment when medically necessary		$20 copayment when medically necessary	
Emergency Room Visit	$100 copayment (waived if admitted)	Network benefit applies	$70 copayment (waived if admitted)	Network benefit applies
Medical/Surgical Benefits	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
Physician Office Visits and covered services provided during office visit.	Single $30 copayment for all covered services provided during the visit and billed by the provider	Basic Medical Program: After annual deductible of $750 per enrollee, $750 per spouse/domestic partner, and $750 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services. After coinsurance maximum of $2,500 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.	$20 copayment for each of the following services: Office visit/office surgery; laboratory/radiology; contraceptives (maximum two copayments per visit).	Basic Medical Program: After annual deductible of $375 per enrollee, $375 per spouse/domestic partner, and $375 per all dependent children combined is met, Plan pays 80 percent of reasonable and customary charges for covered services. After combined coinsurance maximum of $1,033 per enrollee, $1,033 per spouse/domestic partner, and $1,033 per all dependent children combined is met, Plan pays 100 percent of reasonable and customary charges.
Diagnostic Laboratory Services	Single $30 copayment for all covered services provided during the visit and billed by the provider		$20 copayment	
Diagnostic Radiology and Imaging Services (Certain radiology procedures subject to a Prospective Procedure Review)	$30 copayment per visit $75 copayment per visit for procedures subject to Prospective Procedure Review		$20 copayment	
Routine Pediatric Care	Paid-in-full		Paid-in-full	
Routine Newborn Care	Paid-in-full	Up to $100 not subject to deductible or coinsurance	Paid-in-full	Up to $150 not subject to deductible or coinsurance
Routine Health Exams	$30 copayment per visit	Basic Medical Benefits up to $50 per calendar year for an active employee age 50 or older. This benefit is not subject to deductible or coinsurance. There is no Basic Medical coverage for routine health exams for spouses, retirees, vestees or dependent survivors.	$20 copayment for the office visit. An additional $20 copayment for any laboratory/radiology services provided during the visit.	Basic Medical Benefits up to $250 per calendar year for active employees age 50 or older and their covered spouses/domestic partners. No coverage for retirees, vestees, or dependent survivors.
Adult Immunizations	$30 copayment per visit	No coverage	$20 copayment	No coverage
Outpatient Surgical Locations	$75 copayment per visit	Basic Medical Benefits	$30 copayment	Basic Medical Benefits
Emergency Ambulance Service	Local commercial ambulance covered except first $35		Local commercial ambulance covered except first $35	
Prostheses and Orthotic Devices	Paid-in-full	Basic Medical benefits for Prostheses/Orthotic devices that meet the individual's functional needs when obtained from a non-participating provider.	Paid-in-full	Basic Medical benefits for Prostheses/Orthotic devices that meet the individual's functional needs when obtained from a non-participating provider.

2010 NYSHIP Benefit Plan Comparison *(continued)*

Program Component	The Excelsior Plan – An Empire Plan Option		The Empire Plan	
Medical/Surgical Benefits	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
External Mastectomy Prostheses	Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.		Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.	
Chiropractic Treatment and Physical Therapy	$30 copayment for all covered services provided during the visit and billed by the provider.	No Coverage	$20 copayment for each office visit. An additional $20 copayment for radiology and diagnostic laboratory services provided during the visit (maximum of two copayments per visit).	$250 annual deductible per enrollee; $250 per enrolled spouse/domestic partner; $250 per all dependent children combined. After combined maximum of $1,500 per enrollee; $1,500 per enrolled spouse/domestic partner; $1,500 per all dependent children combined is met, the Plan pays 50 percent of the network allowance.
Home Care Services, Skilled Nursing Services and Durable Medical Equipment	Paid-in-full through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After meeting Basic Medical deductible, Plan pays up to 50 percent of HCAP network allowance.	Paid-in-full through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After meeting Basic Medical deductible, Plan pays up to 50 percent of HCAP network allowance.
Mental Health and Substance Abuse Benefits	**Network Providers/Facilities**	**Non-Network**	**Network Providers/Facilities**	**Non-Network**
Inpatient Services – Approved Facilities	$250 deductible per stay for enrollee, $250 per spouse/domestic partner, and $250 per all dependent children combined (maximum of four deductibles per year for each).	No coverage in a non-network facility except network benefits apply in the event of an emergency or when there is no network facility available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.	Paid-in-full No deductibles No annual or lifetime benefit maximums	Coinsurance of 10 percent of billed charges up to combined annual inpatient/outpatient maximum of $1,500 for enrollee, $1,500 for spouse/domestic partner and $1,500 for all dependent children combined. Coinsurance maximums apply as follows: Enrollee pays the first $500, the Program reimburses the enrollee the next $500 of coinsurance (upon written request from enrollee), then the enrollee pays the final $500 of coinsurance.
Inpatient Practitioner Treatment or Consultation	Paid-in-full	After annual deductible of $750 per enrollee, $750 per spouse/domestic partner, and $750 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services. After coinsurance maximum of $2,500 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.	Paid-in-full	After annual deductible of $375 per enrollee, $375 per spouse/domestic partner, and $375 per all dependent children combined is met, Plan pays 80 percent of reasonable and customary charges for covered services. After combined coinsurance maximum of $1,033 per enrollee, $1,033 per spouse/domestic partner, and $1,033 per all dependent children combined is met, Plan pays 100 percent of reasonable and customary charges.
Outpatient Services	Paid-in-full benefit for up to three visits per crisis; Additional visits subject to a $30 copayment.		Paid-in-full benefit for up to three visits per crisis Additional visits subject to a $20 copayment	
Covered Outpatient Substance Abuse Services	$30 copayment per visit		$20 copayment per visit	
Emergency Room Visit	$100 copayment (waived if admitted)	Network benefit applies	$70 copayment (waived if admitted)	Network benefit applies
Emergency Ambulance Service	Local commercial ambulance covered except first $35		Local commercial ambulance covered except first $35	
Prescription Drug Program				
Prescription Drug Benefits	**Mail Order Pharmacy**		**Participating Retail Pharmacy**	
Level 1	**Excelsior Plan** (most generics)	**Empire Plan** (generics)	**Excelsior Plan** (most generics)	**Empire Plan** (generics)
Up to 30 Days	$10	$5	$10	$5
31-90 Days	$20	$5	$25	$10
Level 2	**Excelsior Plan** (most Preferred Brand-Name Drugs)	**Empire Plan** (Preferred Brand-Name Drugs)	**Excelsior Plan** (most Preferred Brand-Name Drugs)	**Empire Plan** (Preferred Brand-Name Drugs)
Up to 30 Days	$30	$15	$30	$15
31-90 Days	$60	$20	$75	$30
Level 3	**Excelsior Plan** (all other covered drugs)	**Empire Plan** (all other covered drugs)	**Excelsior Plan** (all other covered drugs)	**Empire Plan** (all other covered drugs)
Up to 30 Days	$65	$40	$65	$40
31-90 Days	$130	$65	$160	$70

A Specialty Drug Program is scheduled to be implemented effective April 1, 2010 for both The Empire Plan and The Excelsior Plan.
Empire Plan: If enrollee's doctor believes a brand drug is medically necessary, enrollee may appeal mandatory generic substitution. If approved, level 3 copayment applies and ancillary fee is waived. Quantity level limits exist for erectile dysfunction and migraine medications.
Excelsior Plan: No generic appeal, Level 3 copayment and applicable ancillary fee is charged. Quantity level limits are included in most therapeutic categories. Plan benefit maximums are included for all smoking cessation and infertility therapies.