NYSHIP
New York State Health Insurance Program

# 2014 NYSHIP Benefit Plan Comparison

| Program Component | THE EMPIRE PLAN | | THE EXCELSIOR PLAN — AN EMPIRE PLAN OPTION | |
|---|---|---|---|---|
| **Hospital Benefits**[1] | **Network** | **Non-Network** | **Network** | **Non-Network** |
| Covered Inpatient Services<br>*Preadmission Certification Required* | Paid-in-full | Not subject to deductible. Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels. | $250 copayment per stay | 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. |
| Skilled Nursing Facility Care (No coverage if Medicare primary) | Paid-in-full in an approved facility when medically necessary and provided in lieu of hospitalization | | Paid-in-full in an approved facility when medically necessary and provided in lieu of hospitalization | |
| 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 | Not subject to deductible. Coinsurance of 10 percent of billed charges or $75 (whichever is greater) up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels. | Paid-in-full | |
| Covered Outpatient Services (diagnostic radiology/laboratory) | $40 copayment per visit | | $75 copayment per visit | |
| Covered Outpatient Surgery | $60 copayment per visit | | $100 copayment per visit | |
| Physical Therapy following related Hospitalization or Inpatient/Outpatient Surgery | $20 copayment when medically necessary | | $30 copayment when medically necessary | |
| Emergency Room Visit | $70 copayment (waived if admitted) | Network benefit applies | $100 copayment (if admitted, only inpatient copayment applies) | Network benefit applies |
| **Medical/Surgical Benefits**[1] | **Participating Providers** | **Non-Participating** | **Participating Providers** | **Non-Participating** |
| Physician Office Visits and covered services provided during office visit | $20 copayment for each of the following services: Office visit/office surgery; laboratory/radiology. No copayment for prenatal visits, well child care, preventive care services and certain approved contraceptive drugs and devices. | Basic Medical Program: After the combined annual deductible of $1,000 per enrollee, $1,000 per spouse/domestic partner, and $1,000 per all dependent children combined is met, Plan pays 80 percent of reasonable and customary charges for covered services.[3] After combined coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined is met, Plan pays 100 percent of reasonable and customary charges.[2] | Single $30 copayment for all covered services provided during the visit and billed by the provider. No copayment for prenatal visits, well child care, preventive care services and certain approved contraceptive drugs and devices. | Basic Medical Program: After the combined annual deductible of $1,250 per enrollee, $1,250 per spouse/domestic partner, and $1,250 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined coinsurance maximum of $4,000 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4] |
| Diagnostic Laboratory Services | $20 copayment | | Single $30 copayment for all covered services provided during the visit and billed by the provider. | |
| Diagnostic Radiology and Imaging Services (Certain radiology procedures subject to a Prospective Procedure Review) | $20 copayment | | $30 copayment per visit<br>$75 copayment per visit for procedures subject to Prospective Procedure Review | |
| Routine Pediatric Care | Paid-in-full | Basic Medical Program benefits | Paid-in-full | Basic Medical Program benefits |
| Routine Newborn Care | Paid-in-full | Not subject to deductible or coinsurance | Paid-in-full | Not subject to deductible or coinsurance |
| Routine Health Exams | No copayment for covered preventive care services as defined by the Patient Protection and Affordable Care Act. Other covered services subject to $20 copayment per visit. | Routine health exams are covered for you, the active employee, if you are age 50 or over and for your spouse or domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance. | No copayment for covered preventive care services as defined by the Patient Protection and Affordable Care Act. Other covered services subject to $30 copayment per visit. | Basic Medical Program benefits 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. |
| Adult Immunizations | | No coverage | | No coverage |
| Outpatient Surgical Locations | $30 copayment | Basic Medical Program benefits | $75 copayment per visit | Basic Medical Program benefits |

[1] Certain covered preventive care services are paid-in-full when received from a participating provider or at a network hospital.
[2] The annual coinsurance maximum for The Empire Plan is shared among the Basic Medical Program, non-network Hospital Program coverage and non-network Mental Health and Substance Abuse Program coverage.
[3] The annual deductible for The Empire Plan and the Excelsior Plan is shared among the Basic Medical Program, non-network coverage under the Home Care Advocacy Program and the Mental Health and Substance Abuse Program.
[4] The annual coinsurance maximum for the Excelsior Plan is shared among the Basic Medical Program and non-network coverage under the Mental Health and Substance Abuse Program.

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|---|---|---|---|---|
| **Medical/Surgical Benefits** | **Participating Providers** | **Non-Participating** | **Participating Providers** | **Non-Participating** |
| 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 Program benefits for Prostheses/ Orthotic devices that meet the individual's functional needs. | Paid-in-full | Basic Medical Program benefits for Prostheses/ Orthotic devices that meet the individual's functional needs. |
| 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 | $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 spouse/domestic partner; $250 per all dependent children combined. The Plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum. | $30 copayment for all covered services provided during the visit and billed by the provider. | No coverage |
| Home Care Services, Skilled Nursing Services and Durable Medical Equipment | Paid-in-full when precertified through Home Care Advocacy Program (HCAP). | First 48 hours of nursing care not covered. After the combined annual deductible is met, Plan pays up to 50 percent of HCAP network allowance. There is no coinsurance maximum. | Paid-in-full when precertified through Home Care Advocacy Program (HCAP). | First 48 hours of nursing care not covered. After the combined annual deductible is met, Plan pays up to 50 percent of HCAP network allowance. There is no coinsurance maximum. |
| **Mental Health and Substance Abuse Benefits** | **Network Providers/Facilities** | **Non-Network** | **Network Providers/Facilities** | **Non-Network** |
| Inpatient Services – Approved Facilities | Paid-in-full<br>No annual or lifetime benefit maximums | Not subject to deductible. Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner and $3,000 per all dependent children combined.[2] When combined coinsurance maximum is satisfied, benefits are provided at network level. | $250 copayment per stay | 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. |
| Inpatient Practitioner Treatment or Consultation | Paid-in-full | | Paid-in-full | |
| Outpatient Services | Paid-in-full benefit for up to three visits per crisis; additional visits subject to a $20 copayment | After the combined annual deductible of $1,000 per enrollee; $1,000 per enrolled spouse/domestic partner; $1,000 per all dependent children combined is met, the Plan pays 80 percent of reasonable and customary charges for covered services.[3] After the combined coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined is reached, the Plan pays 100 percent of reasonable and customary amount for covered services.[2] | Paid-in-full benefit for up to three visits per crisis; Additional visits subject to a $30 copayment. | After the combined annual deductible of $1,250 per enrollee, $1,250 per spouse/domestic partner, and $1,250 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined coinsurance maximum of $4,000 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4] |
| Covered Outpatient Substance Abuse Services | $20 copayment per visit | | $30 copayment per visit | |
| Emergency Room Visit | $70 copayment (waived if admitted) | Network benefits apply | $100 copayment (if admitted, only inpatient copayment applies) | Network benefits apply |
| Emergency Ambulance Service | Ambulance service covered when medically necessary | | Local commercial ambulance covered except first $35 | |

**Prescription Drug Program[5,6]**

| | Empire Plan | | Excelsior Plan | |
|---|---|---|---|---|
| | **Mail Order Pharmacy** | **Network Pharmacy** | **Mail Order Pharmacy** | **Network Pharmacy** |
| **Level 1** | (most generics) | | (most generics) | |
| Up to 30 Days | $5 | $5 | $10 | $10 |
| 31-90 Days | $5 | $10 | $20 | $25 |
| **Level 2** | (Preferred Drugs) | | (Preferred Drugs) | |
| Up to 30 Days | $25 | $25 | $40 | $40 |
| 31-90 Days | $50 | $50 | $95 | $95 |
| **Level 3** | (all other covered drugs) | | (all other covered drugs) | |
| Up to 30 Days | $45 | $45 | $70 | $70 |
| 31-90 Days | $90 | $90 | $180 | $180 |

[5] 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.
[6] Excelsior Plan: No generic appeal, Level 3 copayment and applicable ancillary fee is charged. Quantity level limits are included in most therapeutic categories.