Exhibit II.D.2

AT A GLANCE

SEHP | Student Employee Health Plan

For Graduate Student Employees and for their enrolled Dependents; and for COBRA Enrollees and Young Adult Option Enrollees with SEHP benefits

This guide briefly describes the principal New York State Health Insurance Program (NYSHIP) SEHP benefits. It is not a complete description and is subject to change. If you have questions about eligibility, enrollment procedures or the cost of health insurance, contact the Health Benefits Administrator (HBA) on your SUNY campus. CUNY SEHP enrollees with questions may contact their HBA at the CUNY University Benefits Office.

NEW YORK STATE | Student Employee Health Plan

New York State Department of Civil Service
Employee Benefits Division, Albany, NY 12239
www.cs.ny.gov/employee-benefits

January 1, 2017

WHAT'S NEW

- **In-network Out-of-Pocket Limit –** For 2017, the maximum out-of-pocket limit for covered, in-network services under The Plan is $7,150 for Individual coverage and $14,300 for Family coverage, split between the Hospital, Medical/ Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. See page 3 for more information.
- **Substance Abuse Treatment Coverage –** In June 2016, Governor Cuomo signed legislation to combat heroin and opioid abuse that includes new health insurance requirements. The Empire Plan already has in place programs and services that are in compliance with the new legislation. Please contact the appropriate program administrator with questions regarding coverage for treatment (see *Contact Information*, page 23).
- **2017 Empire Plan Flexible Formulary Drug List –** The annual update lists the most commonly prescribed generic and brand-name drugs included in the 2017 Empire Plan Flexible Formulary and newly excluded drugs with 2017 Empire Plan Flexible Formulary alternatives.

Quick Reference

The NYSHIP Student Employee Health Plan is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan has six main parts:

Hospital Program

administered by Empire BlueCross BlueShield

Provides coverage for inpatient and outpatient services provided by a hospital or birthing center and for hospice care. Also provides inpatient Benefits Management Program services for preadmission certification of scheduled hospital admissions or within 48 hours after an emergency or urgent admission.

Medical/Surgical Program

administered by UnitedHealthcare

Provides coverage for medical services, such as office visits, surgery and diagnostic testing under the network and non-network programs. Coverage for chiropractic care and physical therapy is provided through the Managed Physical Medicine Program. Home care services provided in lieu of hospitalization and diabetic supplies provided by the Home Care Advocacy Program (HCAP). Benefits Management Program services for Prospective Procedure Review for MRI, MRA, CT, PET scan and Nuclear Medicine tests.

Mental Health and Substance Abuse Program

administered by Beacon Health Options, Inc.

Provides coverage for inpatient and outpatient mental health and substance abuse services. Also provides preadmission certification of inpatient and certain outpatient services, concurrent reviews, case management and discharge planning.

Prescription Drug Program

administered by CVS Caremark

Provides coverage for prescription drugs dispensed through Empire Plan network pharmacies, the mail service pharmacy, the specialty pharmacy and non-network pharmacies.

Dental Program

administered by EmblemHealth 1-800-947-0101

Provides coverage for dental examinations, cleaning and bitewing X-rays. Also provides discounts on other services.

Vision Program

administered by Davis Vision 1-888-588-4823

Provides coverage for routine eye examinations, eyeglasses or contact lenses.

See *Contact Information* on page 23.

2017 Copayments at a Glance†

Medical/Surgical Program	**Participating Provider Program*** $10 copayment – Office visit, office surgery, urgent care center visit, convenience care clinic visit, infertility treatment visit, allergy testing and diagnostic mammography $10 copayment – Diagnostic laboratory tests and radiology (not performed during an office visit) **Chiropractic Treatment or Physical Therapy Services (Managed Physical Medicine Program)** $10 copayment – Office visit, up to 15 chiropractic visits per person per calendar year; up to 60 physical therapy visits per diagnosis $10 copayment – Diagnostic laboratory tests or radiology
Hospital Program	$15 copayment – Surgery, diagnostic radiology including diagnostic mammography, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital or an extension clinic (including outpatient surgical locations) $25 copayment – Emergency room care $200 copayment – Per admission for covered inpatient hospital stays $10 copayment – Per visit for medically necessary physical therapy (following related hospitalization or surgery); up to 60 visits
Mental Health and Substance Abuse Program	$10 copayment – Office visit to network practitioner* $25 copayment – Emergency room care $200 copayment – Per admission for a covered inpatient mental health or substance abuse stay
Prescription Drug Program	**Up to a 30-day supply from a participating retail pharmacy, mail service or designated specialty pharmacy:** $5 copayment – Level 1 or generic drug $25 copayment – Level 2 or preferred brand-name drug $45 copayment – Level 3 or non-preferred brand-name drug **31- to 90-day supply through the mail service or designated specialty pharmacy:** $5 copayment – Level 1 or generic drug $50 copayment – Level 2 or preferred brand-name drug $90 copayment – Level 3 or non-preferred brand-name drug Certain covered drugs do not require a copayment (see page 16).
Dental Program	$20 copayment – Participating provider visit $10 copayment – Filling
Vision Program	$10 copayment – Routine eye exam

† *Preventive care services under the Patient Protection and Affordable Care Act, women's health care services and certain other covered services are not subject to copayment.*

* *Office visits to a network practitioner are subject to a 15-visit annual limit per covered individual. For visit 16 and beyond, non-network coverage applies. Certain covered services are not subject to the 15-visit per person limit.*

Benefits Management Program

The Empire Plan Benefits Management Program helps to protect the enrollee and allows the Plan to continue to cover essential treatment for patients by coordinating care and avoiding unnecessary services. The Benefits Management Program precertifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient Medical Case Management. In order to receive maximum benefits under the Plan, following the Benefits Management Program requirements – including obtaining precertification for certain services – is required when The Empire Plan is your primary coverage.

YOU MUST CALL
for preadmission certification

You must call The Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program (administered by Empire BlueCross BlueShield):

- Before a scheduled (nonemergency) hospital admission.
- Before a maternity hospital admission.
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.

If you do not call, or if the Hospital Program does not certify the hospitalization, the Plan pays up to 50 percent of the allowable amount after your $200 copayment. If the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.

Other Benefits Management Program services provided by the Hospital Program include:

- Concurrent review of hospital inpatient treatment
- Discharge planning for medically necessary services post-hospitalization
- Inpatient Medical Case Management for coordination of covered services for certain catastrophic and complex cases that may require extended care
- The Future Moms Program for early risk identification

YOU MUST CALL
for Prospective Procedure Review

You must call The Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program (administered by UnitedHealthcare) before receiving the following scheduled (nonemergency) diagnostic tests:

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computerized Tomography (CT)
- Positron Emission Tomography (PET) scan
- Nuclear Medicine test

Precertification is required unless you are having the test as an inpatient in a hospital. If you do not call, you will pay a larger part of the cost. If the test or procedure is determined not to be medically necessary, you will be responsible for the entire cost.

Other Benefits Management Program services provided by the Medical Program include:

- Coordination of Voluntary Specialist Consultant Evaluation
- Outpatient Medical Case Management for coordination of covered services for certain catastrophic and complex cases that may require extended care

Out-Of-Pocket Costs

In-network Out-of-Pocket Limit

As a result of Patient Protection and Affordable Care Act provisions, there is a limit on the amount you will pay out of pocket for in-network services/supplies received during the Plan year.

Out-of-Pocket Limit: The amount you pay for network services/supplies is capped at the out-of-pocket limit. Network expenses include copayments you make to providers, facilities and pharmacies (network expenses do not include premiums, deductibles or coinsurance). Once the out-of-pocket limit is reached, network benefits are paid in full.

Beginning January 1, 2017, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $4,650 for in-network expenses incurred under the Hospital Program, Medical/Surgical Program and Mental Health and Substance Abuse Program
- $2,500 for in-network expenses incurred under the Prescription Drug Program

Family Coverage

- $9,300 for in-network expenses incurred under the Hospital Program, Medical/Surgical Program and Mental Health and Substance Abuse Program
- $5,000 for in-network expenses incurred under the Prescription Drug Program

Out-of-Network Combined Annual Deductible

The combined annual deductible is $100 per covered individual.

The combined annual deductible must be met before Basic Medical Program expenses, non-network expenses under the Home Care Advocacy Program and non-network outpatient expenses under the Mental Health and Substance Abuse Program will be considered for reimbursement.

Preventive Care Services

Your benefits include provisions for expanded coverage of preventive health care services required by the federal Patient Protection and Affordable Care Act (PPACA) implementation timetable.

When you meet established criteria (such as age, gender, and risk factors) for certain preventive care services, those preventive services are provided to you at no cost when you use an Empire Plan participating provider or network facility. See the *2017 Empire Plan Preventive Care Coverage Chart* for examples of covered services.

For further information on PPACA preventive care services and criteria to receive preventive care services at no cost, visit www.hhs.gov/healthcare/rights/preventive-care.

Hospital Program

PRESS OR SAY 2 **Call the Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 2 to reach the Hospital Program.**

The Hospital Program provides benefits for services provided in a network or non-network inpatient or outpatient hospital setting or hospice setting. Services must be covered and medically necessary. The Medical/Surgical Program provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by the Hospital Program.

Call the Hospital Program for preadmission certification or if you have questions about your benefits, coverage or an Explanation of Benefits (EOB) Statement.

Network coverage applies when you receive emergency or urgent services in a non-network hospital, or when you use a non-network hospital because you do not have access to a network hospital. Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Network Coverage

You pay only applicable copayments for services/supplies provided by a hospital or hospice that is part of The Empire Plan network. No deductible or coinsurance applies. Network coverage also applies when The Empire Plan provides coverage that is secondary to other coverage.

Non-network Coverage

When you use a hospital that is not part of The Empire Plan network, your out-of-pocket costs are higher. After you pay your deductible amount, the Plan pays 80 percent of the allowable amount. You are responsible for the balance.

Allowable amount means the amount you actually paid for covered, medically necessary services or the network allowance as determined by Empire BlueCross BlueShield.

Hospital Inpatient

YOU MUST CALL
for preadmission certification (see page 3).

The Hospital Program provides unlimited days of care for covered medical or surgical care in a hospital, including inpatient detoxification. An additional copayment is required if the hospitalization occurs more than 90 days after a previous discharge for the same illness or injury.

Network Coverage

$200 copayment per person per admission. The Plan pays 100 percent of the allowable amount after you pay the copayment.

Maternity care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section, or first 96 hours following a cesarean section, are presumed medically necessary and covered at the same copayment and coverage level as other inpatient admissions. If you choose early discharge following delivery, you may request one paid-in-full home care visit.

Non-network Coverage

$200 copayment per person per admission. The Plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Maternity care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section, or first 96 hours following a cesarean section, are presumed medically necessary. The plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Hospital Outpatient

If you are admitted as an inpatient directly from the Emergency Department or another outpatient department, the Emergency or outpatient department copayment is waived, and only the inpatient copayment applies.

Emergency Department

Network Coverage

You pay one $25 copayment per visit to an Emergency Department, including use of the facility for emergency care, services of the attending emergency room physician, services of providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.

Non-network Coverage

Network coverage applies to emergency services received in a non-network hospital.

Emergency is defined as a medical condition with symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate care to put the person's life in jeopardy or cause serious impairment of bodily functions.

Outpatient Department

Services covered in a network hospital outpatient department or extension clinic are the same services covered when received in a non-network facility.

Network Coverage

You pay one $15 copayment per visit for outpatient surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia.

You pay one $15 copayment per visit to a hospital outpatient Urgent Care facility.

The following services are paid in full when designated preventive according to the Patient Protection and Affordable Care Act:

- Bone mineral density tests
- Colonoscopies
- Mammograms
- Pap smears
- Proctosigmoidoscopy screenings
- Sigmoidoscopy screenings

Non-network Coverage

The Plan pays 80 percent of allowable amount after you meet the combined $100 annual deductible (per covered individual).

Physical therapy following a related hospitalization or related inpatient or outpatient surgery is subject to a $10 copayment per visit. Up to 60 medically necessary visits are covered under Network coverage.

Physical therapy covered under the Non-network benefit is subject to a separate combined $100 deductible for physical therapy and chiropractic care (see page 12).

Medically necessary physical therapy is covered under the Managed Physical Medicine Program when not covered under the Hospital Program (see page 12).

Infertility

Network Coverage

The following services provided in the inpatient or outpatient departments of a hospital are covered: artificial/intra-uterine insemination; inpatient and/or outpatient surgical or medical procedures performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility and associated diagnostic tests and procedures including, but not limited to, those described in New York State Insurance Law as set forth in Chapter 82 of the Laws of 2002.

Non-network Coverage

Outpatient infertility treatment: The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Inpatient infertility treatment: The Plan pays 80 percent of the allowable amount after you pay the $200 copayment.

Hospice Care

Network Coverage

Care provided by a licensed hospice program is paid in full for up to 210 days.

Non-network Coverage

The Plan pays up to 100 percent of allowable amount for up to 210 days for care provided by a licensed hospice program.

Medical/Surgical Program

PRESS OR SAY 1 **Call the Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 1 to reach the Medical/Surgical Program.**

The Medical/Surgical Program provides benefits for medically necessary, covered services received from a physician or other practitioner licensed to provide medical/surgical services. It also covers services received from facilities not covered under the Hospital Program, such as outpatient surgical centers, imaging centers, laboratories, urgent care centers and convenience care clinics. Call the Medical Program if you have questions about the status of a provider, Plan coverage or your benefits.

Network Coverage

Network coverage applies when you use a physician or provider who participates in The Empire Plan network.

When you receive covered services from a participating provider, you pay only applicable copayments. Women's health care services, many preventive care services and certain other covered services are paid in full (see pages 8-11).

The Plan does not guarantee that network providers are available in all specialties or geographic locations. To learn whether a provider participates, check with the provider directly, call the Medical Program or visit our web site and click Find a Provider. Always confirm the provider's participation before you receive services.

15-visit Per Person Limit

Most types of visits to a network provider are subject to a 15-visit per person annual limit. Non-network coverage applies after you reach the annual limit.

Preventive Care visits are not subject to the 15-visit per person limit.

Note: Any visit you make to your SUNY Campus Student Health Center (which is not a network provider), does not count toward the 15-visit per person limit. (This does not apply to CUNY SEHP enrollees.)

Non-network Coverage

Non-network coverage applies when you use a physician or provider who is not in The Empire Plan network, and when you exceed the 15-visit limit in a network setting, for those services that are subject to the limit. Your out-of-pocket costs are higher when you use non-network coverage.

Once you meet the combined $100 annual deductible per covered individual (see page 4), the Plan pays 80 percent of the allowable amount for covered services.

Allowable amount means the amount you actually paid for covered, medically necessary services, or the network allowance as determined by UnitedHealthcare, whichever is lower. The Network allowance generally equates to 24 percent of FAIR Health© Usual and Customary professional rates.* FAIR Health© is a nonprofit organization approved by the State of New York as a benchmarking database. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the usual and customary rate for these services in your geographic area or ZIP code.

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Office Visit, Office Surgery and Laboratory and Radiology

Network Coverage

You have network coverage for up to 15 visits per person per calendar year for office visits, including office surgery, provided by a network provider, subject to a $10 copayment per visit. The copayment includes diagnostic laboratory tests and radiology done during the office visit.

Certain visits and laboratory/radiology services are paid in full and do not count toward the 15-visit per person annual limit, including well-child care, prenatal and postnatal office visits included in your provider's delivery charge, visits for preventive care, women's health care including certain contraceptives provided in a physician's office, dialysis, chemotherapy and radiation therapy.

Visits to a participating Urgent Care Center that is not affiliated with a hospital are subject to a $10 copayment, but do not count toward the 15-visit per person annual limit for network benefits.

Diagnostic laboratory tests and radiology, including mammograms, not performed during an office visit are covered subject to a separate $10 copayment, but do not count toward the 15-visit per person annual limit for network benefits.

An annual routine mammogram is covered and paid-in-full for persons 40 years of age and older, and does not count toward the 15-visit per person annual limit for network benefits.

Non-network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Network Coverage	Non-network Coverage
A routine single baseline mammogram for individuals 35 through 39 years of age is covered subject to a $10 copayment, and does not count toward the 15-visit per person annual limit for network benefits.	
Infertility treatment: $10 copayment for covered services such as artificial/intrauterine insemination (see *Infertility*, page 7) provided during an office visit.	**Infertility treatment:** The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible (covered services only, see page 7).
Second surgical opinion: $10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; subject to the 15-visit per person annual limit. One paid-in-full in-hospital consultation in each field per confinement.	**Second surgical opinion:** Same limits apply as under network coverage. The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible.
Second opinion for cancer diagnosis: $10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer, recurrence of cancer or a recommended course of treatment for cancer.	**Second opinion for cancer diagnosis:** Covered services are the same as under network coverage. The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible.

Routine Health Exams

Network Coverage	Non-network Coverage
Preventive annual routine health exams are paid in full and are not subject to the 15-visit per person annual limit. Other covered services received during a routine health exam may be subject to copayment(s).	Routine physicals are covered once every two years for the active employee under age 40, or annually for the active employee over age 40. There is no coverage for routine health exams for a spouse or domestic partner. The Plan pays 80 percent of the allowable amount for covered services. This benefit is not subject to copayment, deductible or the 15-visit per person annual limit. Covered services, such as laboratory tests and screenings provided during the office visit for a routine exam that fall outside the scope of a routine exam, are subject to deductible and coinsurance. For further information contact the Medical/Surgical Program.

Routine Well-child Care

Network Coverage	Non-network Coverage
Paid-in-full benefit for children up to age 19, including examinations and immunizations administered pursuant to pediatric guidelines. Well-child care visits do not count toward the 15-visit per person annual limit for network benefits.	The Plan pays 100 percent of the allowable amount. This benefit is not subject to deductible or coinsurance.

Enteral Formulas and Modified Solid Food Products

Non-network Coverage

For prescribed enteral formulas, the Plan pays up to 80 percent of the allowable amount after you meet the combined annual deductible. For certain prescribed modified solid food products, the Plan pays up to 80 percent of the allowable amount after you meet the combined annual deductible, up to a total maximum reimbursement of $2,500 per covered person per calendar year.

Ambulatory Surgical Center

Network Coverage

$10 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a surgical center.

Non-network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible. The allowed amount will be a facility rate based on information provided by a third-party vendor. This allowable generally equates to 33 percent of FAIR Health© Usual and Customary facility rates.*

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Adult Immunizations

Network Coverage

The following adult immunizations are paid in full based on recommendations by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:

- Influenza (flu)*
- Pneumococcal (pneumonia)*
- Measles, Mumps, Rubella (MMR)
- Varicella (chickenpox)
- Tetanus, Diphtheria, Pertussis (Td/Tdap)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Meningococcal (meningitis)*
- Herpes Zoster (shingles),* if the recipient is age 60 or older

** Covered under the Prescription Drug Program at pharmacies that participate in CVS Caremark's national vaccine network. Other vaccines are not covered when received in a pharmacy setting (see page 19).*

Non-network Coverage

Not covered.

Allergy Care

Network Coverage

Office visits are covered, subject to a $10 copayment and the 15-visit per person annual limit. Basic skin tests done during an office visit are not subject to a separate copayment. Tests provided on a different date or at a different location require a separate $10 copayment, but do not count toward the 15-visit per person limit. Allergy injections and extracts are not covered (see *Exclusions*, page 22).

Non-network Coverage

Not covered.

Pregnancy Termination

Network Coverage

Paid-in-full benefit; does not count toward 15-visit per person annual limit.

Non-network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Ambulance Service

Network Coverage

You pay a $15 copayment for local commercial emergency ambulance service.

Emergency Ambulance Transportation is covered when the service is provided by a licensed ambulance service to the nearest hospital where emergency care can be performed, and ambulance transportation is required because of an emergency condition.

Inpatient in a Hospital or Birthing Center

Network Coverage

Covered services received from a network provider while you are an inpatient are paid in full and do not count toward the 15-visit per person limit.

Paid-in-full benefit for preadmission and/or presurgical testing for radiology, anesthesiology and pathology.

Non-network Coverage

The Plan pays 80 percent of the allowable amount for covered services after you meet the combined $100 deductible.

Network coverage applies.

Outpatient Department of a Hospital

Network Coverage

Paid-in-full benefit for covered outpatient services provided in the outpatient department of a hospital by a network provider.

Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, chemotherapy, anesthesiology, radiology, pathology or dialysis when not covered by Empire BlueCross BlueShield; does not count toward 15-visit per person limit.

Non-network Coverage

For covered services by a non-network provider, the Plan pays 80 percent of the allowable amount for covered services after you meet the combined $100 deductible.

The Plan pays up to 100 percent of the allowable amount.

Medical/Surgical Program Benefits for Physician/Provider Services Received in a Hospital Inpatient or Outpatient Setting

When you receive covered services from a physician or other provider in a hospital, and those services are billed by the provider (not the facility), the following Medical/Surgical benefits apply:

Participating Provider Program
Covered services are paid in full when the provider participates in The Empire Plan network.

Basic Medical Program
If you receive covered radiology, anesthesiology or pathology services in connection with covered inpatient or outpatient services at an Empire Plan network hospital and The Empire Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist and pathologist will be paid in full by the Medical/Surgical Program. Services provided by other nonparticipating providers are subject to deductible and coinsurance.

Emergency care in a hospital Emergency Department, provided by:

- An attending emergency department physician is paid in full
- Evaluation and management emergency care billed by an attending Emergency Department physician is paid in full
- Participating and nonparticipating providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams and/or pathology are paid in full
- Other participating providers are paid in full
- Other nonparticipating providers (e.g., surgeons) are considered under non-network coverage and are not subject to deductible and coinsurance.

The Empire Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from nonparticipating (non-network) providers at a network facility without their knowledge. See *Out-of-Network Reimbursement Disclosures* or contact the Medical Program for more information.

Managed Physical Medicine Program

Administered by Managed Physical Network (MPN)

Chiropractic Treatment, Physical Therapy and Occupational Therapy

Network Coverage (when you use MPN)

Each office visit to an MPN provider is subject to a $10 copayment. Related radiology and diagnostic laboratory services billed by the MPN provider are subject to a separate $10 copayment. No more than two copayments per visit will be assessed.

MPN guarantees access to network benefits. If there are no network providers in your area, you must contact MPN prior to receiving services to arrange for network benefits.

Chiropractic treatment: Up to 15 visits per person per calendar year.

Physical therapy: Up to 60 visits per diagnosis, if determined to be medically necessary.

Non-network Coverage (when you don't use MPN)

Non-network benefits apply for covered services received from non-network providers, or after the 15th chiropractic visit per year, or after the 60th physical therapy visit per diagnosis, by a network provider.

Annual deductible: Subject to a separate combined $100 deductible per covered individual for physical therapy and chiropractic treatment, including hospital-based physical therapy. This deductible is separate from the combined annual deductible.

Coinsurance: The Plan pays up to 80 percent of the allowable amount after you meet the annual deductible.

Allowable amount means the amount you actually paid for covered, medically necessary services, or the network allowance as determined by UnitedHealthcare, whichever is lower. The network allowance generally equates to 12 percent of FAIR Health© Usual and Customary professional rates.*

* *Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Home Care Advocacy Program (HCAP)

Diabetic Equipment/Supplies, Home Care Services and Durable Medical Equipment and Supplies provided in lieu of Hospitalization

YOU MUST CALL
for prior authorization

Network Coverage *(when you use HCAP)*	**Non-network Coverage *(when you don't use HCAP)***
Diabetic equipment and supplies, including insulin pumps and Medijectors, are paid in full. To receive diabetic equipment and supplies, call The Empire Plan Diabetic Supplies Pharmacy at 1-888-306-7337. For insulin pumps and Medijectors, you must use a network provider. Call the Medical Program and choose HCAP for prior authorization.	Diabetic equipment and supplies are covered up to 100 percent of the allowable amount; not subject to deductible or coinsurance. The HCAP network allowance generally equates to 50 percent of FAIR Health© Usual and Customary professional rates.*
Home care services provided in lieu of hospitalization are paid in full for 365 visits. To receive this benefit, you must call the Medical Program and choose HCAP for prior authorization.	Home care services are not covered unless precertified. If precertified, the Plan pays 80 percent of allowable amount after you meet the combined annual deductible.
Durable medical equipment and supplies (other than diabetic equipment or supplies) are covered in lieu of hospitalization when precertified. To receive this benefit, you must call the Medical Program and choose HCAP for prior authorization.	Not covered.

Allowable amount means the amount you actually paid for covered, medically necessary services, or the network allowance as determined by UnitedHealthcare, whichever is lower.

Important: If Medicare is your primary coverage and you do not use a Medicare contract provider, your benefits will be reduced. If Medicare is your primary coverage and you live in an area or need supplies while visiting an area that participates in the Medicare Durable Medical Equipment, Prosthetics and Orthotics Supply (DMEPOS) Competitive Bidding Program, you must use a Medicare-approved supplier. Most of New York State is affected by DMEPOS. To locate a Medicare contract supplier, visit www.medicare.gov/supplierdirectory or contact The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program, then Benefits Management Program/Home Care Advocacy Program.

* *Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Mental Health and Substance Abuse Program

PRESS OR SAY 3 **For the highest level of benefits, call the Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 3 to reach the Mental Health and Substance Abuse Program.**

Call the Mental Health and Substance Abuse Program before seeking certain services from a mental health or substance abuse provider, including treatment for alcoholism. The Clinical Referral Line is available 24 hours a day, every day of the year. You will receive the highest level of benefits when you follow the Program requirements for network coverage. You are required to call to precertify certain treatments/services.

In an emergency, go to the nearest hospital Emergency Department. If you are admitted as an inpatient, you or someone acting on your behalf, should call the Mental Health and Substance Abuse Program within 48 hours or as soon as reasonably possible.

Network Coverage

Network coverage applies when you use a physician, provider or facility that participates in The Empire Plan network. When you use a network provider or facility, you pay applicable copayments for covered services. Always confirm the provider's participation before you receive services.

15-visit Per Person Limit
Most types of visits to a network provider are subject to a 15-visit per person annual limit. Non-network coverage applies after you reach the annual limit.

Non-network Coverage

Non-network coverage applies when you use a physician, provider or facility that is not in The Empire Plan network, and when you exceed the 15-visit limit in a network setting for those services that are subject to the limit. Your out-of-pocket costs are higher when you use non-network coverage.

Allowable amount means the lower of billed charges or 110 percent of the Medicare allowance.

Inpatient Services

You should call before an admission to a Mental Health or Substance Abuse facility to ensure that benefits are available. In the case of an emergency admission, certification should be requested as soon as possible. Network facilities are responsible for obtaining precertification. If you use a non-network facility, you may be required to pay the full cost of any stay determined not to be medically necessary.

Approved General Acute Hospital, Psychiatric Hospital or Clinic

The following mental health or substance abuse treatment is covered in an approved general acute hospital, psychiatric hospital or clinic:

- Inpatient hospitalization
- Partial hospitalization
- Intensive outpatient
- Day treatment programs
- 23-hour extended crisis beds
- 72-hour crisis beds
- Residential treatment centers
- Approved group home
- Halfway house

A new copayment is required if admission occurs more than 90 days after the previous admission.

Network Coverage

$200 copayment per person per admission. The Plan pays 100 percent of the allowable amount after you pay the copayment.

Non-network Coverage

$200 copayment per person per admission. The Plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Hospital Emergency Department

Network Coverage

You pay a $25 copayment per visit to an Emergency Department. If you are admitted as an inpatient directly from the outpatient department or Emergency Department, only the inpatient copayment applies (see page 14).

Non-network Coverage

Network coverage applies to Emergency Department visits at a non-network hospital.

Office Visits and other Outpatient Services

Network Coverage

Office visits and other outpatient services, such as outpatient substance abuse rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a $10 copayment and a 15-visit per person annual limit for network benefits. For visit 16 and beyond, non-network coverage applies.

Non-network Coverage

Non-network benefits apply for covered services received from non-network practitioners or after the 15th visit to a network practitioner. Services are subject to the combined $100 annual deductible per covered individual. The Plan pays 80 percent of the allowable amount for covered services after you pay the deductible.

Psychological Testing or Evaluation, Electroconvulsive Therapy and Applied Behavior Analysis Services

YOU MUST CALL
for precertification

Precertification to confirm medical necessity is required before beginning psychological testing or evaluations, electroconvulsive therapy or Applied Behavior Analysis for the treatment of autism spectrum disorder.

Neuropsychological Testing

Neuropsychological testing and evaluations for mental health or substance abuse diagnosis in a network or non-network setting will be reviewed for medical necessity. Only medically necessary services are covered, therefore, precertification by the Mental Health and Substance Abuse Program is recommended before testing or evaluation begins. **Note:** Neuropsychological testing with a medical diagnosis is also covered under the Medical Program. These services will be reviewed by UnitedHealthcare for medical necessity, and precertification is recommended before testing or evaluation begins.

Prescription Drug Program

PRESS OR SAY 4 Call the Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 4 to reach the Prescription Drug Program.

Copayments

You have the following copayments for drugs purchased from a participating pharmacy, the Mail Service Pharmacy or Specialty Pharmacy. You have coverage for prescriptions for more than a 30-day supply through the mail service pharmacy or designated specialty pharmacy.

Drug Category	Up to a 30-day supply from a Participating Pharmacy, Mail Service Pharmacy or Specialty Pharmacy	31- to 90-day supply from the Mail Service Pharmacy or Specialty Pharmacy
Level 1 Drugs or for most **Generic** Drugs	$5	$5
Level 2, **Preferred** Drugs or Compound Drugs	$25	$50
Level 3 or **Non-preferred** Drugs	$45	$90

Note: At certain SUNY Campus Student Health Centers, SUNY SEHP enrollees and/or their enrolled dependents are able to fill prescriptions for a $7 copayment for up to a 30-day supply. See your Health Benefits Administrator for more information. (This does not apply to CUNY SEHP enrollees.)

Drugs not Subject to Copayment

Certain covered drugs do not require a copayment when using a Network Pharmacy:

- Oral chemotherapy drugs, when prescribed for the treatment of cancer
- Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices)
- Tamoxifen and Raloxifene, when prescribed for the primary prevention of breast cancer
- Certain preventive adult vaccines when administered by a licensed pharmacist

Brand-name Drugs with Generic Equivalent

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the Level 3 Non-preferred drug copayment plus the ancillary charge, not to exceed the full retail cost of the covered drug.

Ancillary Charge: The difference in cost between the brand-name drug and the generic equivalent.

Exceptions

- If the brand-name drug has been placed on Level 1 of The Empire Plan Flexible Formulary, you will pay the Level 1 copayment.
- You pay only the applicable copayment for the following Level 3 brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. One copayment covers up to a 90-day supply.

New to You Prescriptions Program: Certain maintenance medications require at least two 30-day supplies to be filled 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 the 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 has been previously dispensed. If not, only a 30-day fill will be approved. **Note:** If your drug is pre-packed in a 28-day supply, you will need to have at least two 28-day supplies in the past 180 days in order to meet the New to You requirement.

Flexible Formulary Drug List

The Student Employee Health Plan uses The Empire Plan Flexible Formulary for prescription drugs. The Empire Plan Flexible Formulary drug list is designed to provide enrollees and the Plan with the best value in prescription drug spending.

This is accomplished by:

- Excluding coverage for certain brand-name or generic drugs if the drug has no clinical advantage over other covered medications in the same therapeutic class.
- Placing a brand-name drug on Level 1 or excluding or placing a generic drug on Level 3, subject to the appropriate copayment. These placements may be revised mid-year when such changes are advantageous to The Empire Plan. Enrollees will be notified in advance of such changes.
- Applying the highest copayment to non-preferred drugs that provide no clinical advantage over two or more Level 1 drug alternatives in the same therapeutic class. This may result in no Level 2 brand-name drugs.

Prior Authorization Required

You must have prior authorization for the following drugs, including generic equivalents:

- Abstral
- Actemra
- Acthar HP
- Actimmune
- Actiq
- Adagen
- Adcirca
- Adempas
- Aldurazyme
- Alferon-N
- Ampyra
- Apokyn
- Aralast
- Aranesp
- Arcalyst
- Arestin
- Aubagio
- Aveed
- Avonex
- Benlysta
- Berinert
- Betaseron
- Bethkis
- Bivigam
- Botox
- Bravelle
- Buphenyl
- Carbaglu
- Cayston
- Cerdelga
- Cerezyme
- Cetrotide
- Cholbam
- chorionic gonadotropin (Novarel, Pregnyl)
- Cimzia
- Cinqair
- Cinryze
- Cosentyx
- Cystagon
- Cystaran
- Copaxone
- Daklinza
- deferoxamine (Desferal)
- Dysport
- Egrifta
- Elaprase
- Elelyso
- Eligard
- Enbrel
- Entyvio
- Epclusa
- Epogen/ Procrit
- Esbriet
- Exjade
- Extavia
- Fabrazyme
- Fentora
- Ferriprox
- Firazyr
- Firmagon
- Flolan
- Follistim AQ
- Forteo
- Fuzeon
- Ganirelix
- Gattex
- Gilenya
- Glassia
- Granix
- Growth Hormones
- Harvoni
- Hetlioz
- Humira
- Hyqvia
- Ilaris
- Immune Globulins
- Increlex
- Infergen
- Intron A
- Jadenu
- Jublia
- Juxtapid
- Kalbitor
- Kalydeco
- Kanuma
- Kerydin
- Kineret
- Korlym
- Krystexxa
- Kuvan
- Kynamro
- Lamisil
- Lazanda
- Lemtrada
- Letairis
- Leukine
- leuprolide (Lupron)
- Lidoderm
- Lumizyme
- Lupaneta Pack
- Lupron Depot
- Lupron Depot-Ped
- Makena
- Menopur
- modafanil
- Mozobil
- Myalept
- Myobloc
- Myozyme
- Naglazyme
- Natpara
- Neulasta
- Neumega
- Neupogen
- Northera
- Nplate
- Nucala
- Nuplazid
- Nuvigil
- Ocaliva
- octreotide (Sandostatin)
- Ofev
- Olysio
- Onmel
- Onsolis
- Opsumit
- Orencia
- Orenitram
- Orfadin
- Orkambi
- Otezla
- Otrexup
- Ovidrel
- Pegasys
- PegIntron
- Plegridy
- Praluent
- Prialt
- Procysbi
- Prolastin-C
- Prolia
- Promacta
- Pulmozyme
- Rasuvo
- Ravicti
- Rebif
- Remicade
- Remodulin
- Repatha
- Repronex
- Revatio
- Ribavirin
- Ruconest
- Sabril
- Samsca
- Sandostatin LAR
- Saxenda
- Sensipar
- Serostim
- Signifor
- Simponi
- Soliris
- Somatuline Depot

- Somavert
- Sovaldi
- Sporanox
- Stelara
- Strensiq
- Subsys
- Supprelin LA
- Synagis
- Taltz
- Tazorac
- Tecfidera
- Technivie
- Tikosyn
- Tobi Podhaler
- tobramycin inhalation solution (TOBI)
- Tracleer
- Trelstar
- Tysabri
- Tyvaso
- Uptravi
- Vantus
- Veletri
- Ventavis
- Victrelis
- Viekira Pak
- Vimizim
- Vivitrol
- VPRIV
- Weight Loss Drugs
- Xeljanz
- Xenazine
- Xeomin
- Xolair
- Xyrem
- Zarxio
- Zavesca
- Zemaira
- Zepatier
- Zinbryta
- Zoladex
- zoledronic acid (Reclast)

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization. **The previous list of drugs is subject to change as drugs are approved by the Food and Drug Administration, introduced into the market or approved for additional indications.** For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program. Or, visit our web site, and select Using Your Benefits and then Drugs that Require Prior Authorization.

Excluded Drugs

Certain brand-name and generic drugs are excluded from The Empire Plan Flexible Formulary if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2017 Empire Plan Flexible Formulary drug list includes drugs that are excluded in 2017, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. Check the web site for current information regarding exclusions of newly launched prescription drugs.

Newly Excluded Drugs for 2017

- Acticlate
- Avidoxy DK
- Basaglar
- Clindacin ETZ
- Epiduo Forte
- Evoclin
- Evzio
- Gelsyn-3
- Hexilate FS
- Hymovis
- metformin ER (generic Fortamet)
- metformin ER (generic Glumetza)
- Minocin
- Onzetra
- Solodyn
- Sumaxin CP
- Zembrace

Medical Exception Process for Excluded Drugs

A medical exception process is available for non-formulary drugs that are excluded from coverage.

To request a medical exception, you and your physician must first evaluate whether covered drugs on the Flexible Formulary are appropriate alternatives for your treatment. After an appropriate trial of formulary alternatives, your physician may submit a letter of medical necessity to CVS Caremark that details the formulary alternative trials and any other clinical documentation supporting medical necessity. The physician can fax the exception request to CVS Caremark at 1-888-487-9257.

If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment (and ancillary charge, if applicable) will apply for brand-name drugs.

Note: Drugs that are only FDA approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

Types of Pharmacies

Network Pharmacy

A Network Pharmacy is a retail pharmacy that participates in the CVS Caremark network. When you visit a Network Pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail Network Pharmacy location that participates in the CVS Caremark network, call the Prescription Drug Program or visit our web site and select Find a Provider.

CVS Caremark National Vaccine Network Pharmacy

Select preventive vaccines are covered without copayment when administered at a pharmacy that participates in the CVS Caremark national vaccine network. Vaccines available in a pharmacy are:

- Influenza (flu)
- Pneumococcal (pneumonia)
- Meningococcal (meningitis)
- Herpes Zoster (shingles)* – *requires prescription*

To find out if a pharmacy participates in the CVS Caremark national vaccine network, call the Prescription Drug Program or visit www.empireplanrxprogram.com and select CVS Caremark, then Locate a Pharmacy and Pharmacy locator. Be sure to select "Vaccine network" under "Advanced Search." Only certain pharmacies are part of the CVS Caremark national vaccine network. New York State law prohibits pharmacists from administering vaccines to patients under age 18. Similar laws may be in place in other states. Call the pharmacy in advance to verify availability of the vaccine.

** The Herpes Zoster vaccine is only covered with no copayment for individuals age 60 and older.*

Mail Service Pharmacy

You may fill your prescription by mail through the CVS Caremark Mail Service Pharmacy by using the mail order form. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone, download forms at www.cs.ny.gov/employee-benefits or order online at www.empireplanrxprogram.com. Choose your group and plan, if prompted. Click on Forms on the homepage and scroll down to the CVS Caremark Mail Service Order Form.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services including:

- Refill reminder calls
- Expedited, scheduled delivery of your medications at no additional charge
- All necessary supplies, such as needles and syringes applicable to the medication
- Disease education
- Drug education
- Compliance management
- Side-effect management
- Safety management

Prior authorization is required for some specialty medications. To get started with CVS Caremark Specialty Pharmacy, to request refills or to speak to a specialty-trained pharmacist or nurse, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) between 7:30 a.m. and 9 p.m., Monday through Friday, Eastern time. Choose the Prescription Drug Program, and ask to speak with Specialty Customer Care. If your call is urgent, you may request an on-call pharmacist 24 hours a day, seven days a week.

A complete list of specialty medications included in the Specialty Pharmacy Program is available at www.cs.ny.gov/employee-benefits. Click on Using Your Benefits, then Specialty Pharmacy drug list.

Non-network Pharmacy

If you do not use a Network Pharmacy, or if you do not use your benefit card at a Network Pharmacy, you must submit a claim for reimbursement to: The Empire Plan Prescription Drug Program, c/o CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136.

In most cases, you will not be reimbursed the total amount you paid for the prescription.

- If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the Program would reimburse a Network Pharmacy for that prescription, less your copayment.
- If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the program would reimburse a Network Pharmacy for filling the prescription with that drug's generic equivalent, less your copayment, unless the brand-name drug has been placed on Level 1 of The Empire Plan Flexible Formulary.

Dental Program

The Student Employee Health Plan Dental Program (administered by EmblemHealth) provides coverage for dental care. Visits to a participating Dental Program provider for covered services are subject to a $20 copayment and limited to two visits per 12-month period, per covered individual.

Covered Services

- Initial examination, including charting
- Periodic examination
- Cleaning
- Bitewing X-rays, maximum four X-rays per year

Up to two fillings per 12-month period are covered subject to a $10 copayment per filling when you visit a SEHP dental program participating provider. Certain guidelines apply based on the type of material (e.g., amalgam, composite resin) used in the filling. In some cases, additional out-of-pocket costs may apply.

Participating Provider

To locate a SEHP Dental Program participating provider, you can link to the EmblemHealth web site by accessing www.cs.ny.gov/employee-benefits. From the homepage, click on Other Benefits and then choose Dental, or call EmblemHealth's dedicated Customer Service Center.

ID Card

You will receive a separate identification card from EmblemHealth. Present this identification card before you receive services from a provider who participates in the SEHP Dental Program and/or an EmblemHealth Discounted Dental Access Program provider.

EmblemHealth's Discounted Dental Access Program

As part of the SEHP dental program, you will be automatically enrolled in EmblemHealth's Discounted Dental Access Program. If you utilize a provider who participates in the EmblemHealth Discounted Dental Access Program (and receive services other than the covered services above), you are required to pay the provider directly for all care received, and your liability is reduced to a prearranged discounted access rate. You are not subject to precertification or eligibility verification when you utilize the discounted program.

Participating Provider: To locate a participating provider in the EmblemHealth Discounted Dental Access Program, call EmblemHealth's dedicated Customer Service Center at 1-800-947-0101 for a list of participating providers.

Questions

For eligibility questions, contact the Health Benefits Administrator (HBA) on your campus.

For Customer Service, contact EmblemHealth's dedicated Customer Services Center at 1-800-947-0101 after you have enrolled.

Please direct your correspondence to: EmblemHealth, Attn: NYS Dental Customer Service, P.O. Box 12365, Albany, NY 12212-2365.

Please be sure to include your identification number on all correspondence.

Vision Program

Network Benefits

You are covered for a routine eye exam, subject to a $10 copayment, once in any 24-month period (based on your last date of service).

A limited selection of frames and lenses or daily wear, disposable or planned replacement contact lenses offered by a participating provider at the time and place of an eye exam will be paid in full. This benefit is available only once in any 24-month period. There is no coverage for services received from a nonparticipating provider.

To Receive Services from a Network Provider

- Contact the network provider and schedule an appointment.
- Identify yourself as covered under the SEHP Vision Care Program available through the NYS Vision Plan, which is administered by Davis Vision.
- Give the provider your name and date of birth, or member ID number.

The provider will confirm your eligibility and obtain an authorization to provide services. At the time of your appointment, you are responsible for a $10 copayment for vision services.

To Confirm Eligibility or Locate a Network Provider

Contact Davis Vision, the plan administrator, at 1-888-588-4823 or visit our web site and click on Other Benefits then Vision to access the Davis Vision web site.

Exclusions

Services not covered under the Student Employee Health Plan include, but are not limited to, the following:

- Adult immunizations that are not preventive
- Allergy extracts and injections
- Cardiac rehabilitation
- Care that is not medically necessary
- Cosmetic surgery
- Custodial care
- Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease
- Durable medical equipment and supplies unless provided in lieu of hospitalization and precertified under the Home Care Advocacy Program (HCAP)
- Experimental or investigative procedures
- Hearing aids
- Occupational therapy
- Orthotics
- Prosthetics (except breast prostheses, which are paid in full)
- Reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intrauterine insemination and other services for which coverage is mandated by New York State Insurance Law); cloning
- Routine foot care
- Skilled nursing facility care including rehabilitation
- Speech therapy
- TMJ treatment (except when caused by a medical condition)
- Weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity)

Contact Information

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program.

PRESS OR SAY 1	**Medical/Surgical Program: *Administered by UnitedHealthcare*** Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time. TTY: 1-888-697-9054 P.O. Box 1600, Kingston, NY 12402-1600 Claims submission fax: 845-336-7716 online: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Empire BlueCross BlueShield*** Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans. Representatives are available Monday through Friday, 8 a.m. to 5 p.m., Eastern time. TTY: 1-800-241-6894 New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 Claims submission fax: 888-367-9788 online: www.empireblue.com
PRESS OR SAY 3	**Mental Health and Substance Abuse Program: *Administered by Beacon Health Options, Inc.*** Representatives are available 24 hours a day, seven days a week. TTY: 1-855-643-1476 P.O. Box 1800, Latham, NY 12110 Claims submission fax: 855-378-8309 online: https://ets.valueoptions.com/OnlineClaimSubmission
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS Caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 711 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590
PRESS OR SAY 5	**Empire Plan NurseLine℠: *Administered by UnitedHealthcare*** Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.

Dental Program: *Administered by EmblemHealth:* 1-800-947-0101

Vision Program: *Administered by Davis Vision:* 1-888-588-4823

Benefits on the Web

NYSHIP Online is a complete resource for your health insurance benefits, including:

- Current publications describing your benefits and plan
- Announcements
- An event calendar
- Prescription drug information
- Contact information
- Links to each Empire Plan program administrator web site, which each include a current list of providers

To find the most up-to-date information about your health insurance coverage, visit NYSHIP Online at www.cs.ny.gov/employee-benefits. Choose your group and plan to get to the NYSHIP Online homepage. You can bookmark this page to bypass the login screen.

This document provides a brief look at SEHP medical, dental and vision care benefits. If you have any questions or need claims forms, call the appropriate benefits administrator.

NEW YORK STATE | NYSHIP New York State Health Insurance Program

New York State Department of Civil Service
Employee Benefits Division, Albany, New York 12239

518-457-5754 or 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
www.cs.ny.gov

The NYSHIP Student Employee Health Plan (SEHP) *At A Glance* is published by the Employee Benefits Division of the State of New York Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits. If you have questions, call 1-877-7-NYSHIP (1-877-769-7447) and choose the program you need.

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

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NEW YORK STATE | **NYSHIP**
New York State
Health Insurance Program

Information for the Enrollee, Enrolled Spouse/
Domestic Partner and Other Enrolled Dependents

SEHP At A Glance – January 2017

Please do not send mail or correspondence to the return address above. See boxed address page 23.

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 web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

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Notice of Access to Women's Health Services

This notice is provided in accordance with the NYS Women's Health and Wellness Act. The Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. The Plan covers services required as a result of such examinations. The Plan covers services required as a result of an acute gynecologic condition. The Plan covers all care related to pregnancy. Benefits for these services are paid according to the terms of network or non-network coverage. Benefits Management Program requirements apply (see page 3).

Annual Notice of Mastectomy and Reconstructive Surgery Benefits

The Plan covers inpatient hospital care for lymph node dissection, lumpectomy and mastectomy for treatment of breast cancer for as long as the physician and patient determine hospitalization is medically necessary. The Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery of the other breast to produce a symmetrical appearance. The Plan also covers treatment for complications of mastectomy, including lymphedema and breast prostheses. Benefits Management Program requirements apply (see page 3).

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. To view a copy of the *SBC*, visit www.cs.ny.gov/sbc/sehp/index.cfm. 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 Student Employee Health Plan.