

Summary of Benefits

JANUARY 1, 2010

SEHP

The New York State Health Insurance Program's Student Employee Health Plan (SEHP):

For Graduate Student Employees and their enrolled dependents, COBRA enrollees with SEHP benefits and Young Adult Option enrollees

Call Toll Free 1-877-7-NYSHIP (1-877-769-7447)

For preauthorization of services or if you have a question about eligibility, providers or claims, call the Plan and choose the program you need.

UnitedHealthcare and Empire BlueCross BlueShield representatives are available Monday through Friday, 8:00 a.m. to 4:30 p.m. Eastern time. Mental Health and Substance Abuse and Prescription Drug Program representatives are available 24 hours a day, seven days a week. This number is for both The Empire Plan (another NYSHIP plan) and NYSHIP SEHP (except for the NurseLine option, which is for The Empire Plan only). SEHP dental and vision care plans have separate toll-free numbers (see inside cover).

State of New York Department of Civil Service Employee Benefits Division

Alfred E. Smith State Office Building
Albany, NY 12239

web site: <https://www.cs.state.ny.us>

This guide briefly describes the principal 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 Health Benefits Administrator (HBA) at the CUNY University Benefits Office.



Benefit Summary

The NYSHIP Student Employee Health Plan (SEHP) is a health insurance program for CUNY and SUNY graduate and teaching assistant employees and their families. The plan provides medical, dental and vision care benefits.

Contact Information

Hospital Benefits Program

Empire BlueCross BlueShield

New York State Service Center

P.O. Box 1407, Church Street Station, New York, NY 10008-1407

Medical/Surgical Benefits Program

UnitedHealthcare

P.O. Box 1600, Kingston, NY 12402-1600

Mental Health and Substance Abuse Program

OptumHealth Behavioral Solutions

P.O. Box 5190, Kingston, NY 12402-5190

Prescription Drug Program

The Empire Plan Prescription Drug Program

P.O. Box 5900, Kingston, NY 12402-5900

Dental Care Plan

GHI, NYS Dental Service

P.O. Box 12365, Albany, NY 12212-2365

Vision Care Plan

EyeMed Vision Care

4000 Luxottica Place, Mason, OH 45040-7111

Teletypewriter (TTY) numbers for callers who use a TTY because of a hearing or speech disability.

Empire BlueCross BlueShield **TTY Only 1-800-241-6894**

UnitedHealthcare **TTY Only 1-888-697-9054**

OptumHealth **TTY Only 1-800-855-2881**

The Empire Plan

Prescription Drug Program **TTY Only 1-800-759-1089**

Quick Reference

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

- (1) Hospital Benefits Program**
insured and 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.
Services provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.
- (2) Medical/Surgical Benefits Program**
insured and 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, and Nuclear Medicine tests.
- (3) Mental Health and Substance Abuse Program**
insured by UnitedHealthcare and administered by OptumHealth Behavioral Solution (OptumHealth)
Provides coverage for inpatient and outpatient mental health and substance abuse services.
- (4) Prescription Drug Program**
insured and administered by UnitedHealthcare
UnitedHealthcare partners with Medco Health Solutions, Inc. (Medco) for services including the retail pharmacy network and mail pharmacy services.
Provides coverage for prescription drugs, oral contraceptives and diaphragms through network pharmacies, the Medco Pharmacy (mail service) and non-network pharmacies.
- (5) Dental Care Plan**
administered by GHI 1-800-947-0101
Provides coverage for dental examinations, cleaning and bitewing X-rays. Also provides discounts on other services.
- (6) Vision Care Plan**
administered by EyeMed 1-877-226-1412
Provides coverage for routine eye examinations, eyeglasses or contact lenses.

SEHP Health Insurance Benefit Summary

Annual Benefit Maximums

Annual maximum for prescription drugs, network and non-network combined: \$3,000. The Annual Benefit Maximums for all other NYSHIP SEHP coverage, except prescription drugs:

- Non-network benefits: \$100,000
- All benefits (network and non-network combined): \$350,000

All services must be medically necessary. "Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carriers, whichever is lower.

Benefits Management Program



YOU MUST CALL for preadmission certification

If NYSHIP SEHP coverage is primary for you or your covered dependents:

You must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose Empire BlueCross BlueShield:

- Before a scheduled (non-emergency) hospital admission
- Before a maternity hospital admission
- Within 48 hours after an emergency or urgent hospital admission

If you do not call, or if Empire BlueCross BlueShield does not certify the hospitalization, the Plan pays up to 50 percent of allowable amount after your \$200 copayment.



YOU MUST CALL for Prospective Procedure Review - MRI, MRA, CT, PET and Nuclear Medicine tests

If NYSHIP SEHP coverage is primary for you or your covered dependents:

You must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose UnitedHealthcare for prior authorization before having a scheduled (non-emergency) Magnetic Resonance Imaging (MRI), and effective May 1, 2010, for a Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) or a Nuclear Medicine test, unless you are having the test as an inpatient in a hospital. If you do not call, you will pay a large part of the cost. If the test is determined not to be medically necessary, you will be responsible for the entire cost.

Inpatient & Outpatient Hospital Coverage

Empire BlueCross BlueShield

Empire BlueCross BlueShield pays for covered services provided in an inpatient or outpatient hospital setting. UnitedHealthcare provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by Empire BlueCross BlueShield. Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose Empire BlueCross BlueShield if you have questions about your hospital benefits, coverage or an Explanation of Benefits (EOB) Statement.

Hospital Inpatient • *Semi-Private Room or Birthing Center*



YOU MUST CALL *for preadmission certification*

Network Coverage

Copayment: \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

Coverage Level: The Plan pays 100 percent of allowable amount after you pay the copayment.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

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

Copayment: \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

Coverage Level: The Plan pays 80 percent of allowable amount after you pay the copayment. You are responsible for the balance.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

Maternity Care: Same as network coverage.

Hospital Outpatient

Network Coverage

Surgery, diagnostic radiology, 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) are subject to one copayment of \$15 per visit. The copayment is waived if you are admitted as an inpatient directly from the outpatient department.

You must have prior authorization for an MRI, and effective May 1, 2010, for an MRA, CT, PET or a Nuclear Medicine test (see page 2).

\$10 copayment per visit for up to 60 visits for medically necessary physical therapy following a related hospitalization or related inpatient or outpatient surgery.

Emergency room services, including use of the facility for emergency care and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services are subject to one copayment of \$25 per visit. The copayment is waived if you are admitted as an inpatient directly from the emergency room.

Emergency is defined as the sudden onset of 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.

Paid-in-full benefits for chemotherapy, radiation therapy or dialysis and for preadmission testing and/or presurgical testing prior to an inpatient admission.

Non-Network Coverage

Outpatient Care: Same as network coverage, except subject to an annual deductible of \$100 per covered individual. (Not combined with physical therapy deductible.)

Coinsurance: The Plan pays 80 percent of allowable amount after you meet the \$100 deductible.

Non-network coverage subject to a separate \$100 deductible for all physical therapy. (Not combined with hospital outpatient deductible.)

Emergency Care: Same as network coverage.

Same as network coverage.

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

Same as network coverage.

Hospice Care

Network Coverage

Paid-in-full benefit for up to 210 days when provided by an approved hospice program.

Non-Network Coverage

Plan pays up to 100 percent of allowable amount for up to 210 days.

Medical / Surgical Coverage

UnitedHealthcare

UnitedHealthcare benefits are paid under either network or non-network coverage. Some medically necessary services are paid in full; others are subject to copayment or to a 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 or network dollar maximum. (This does not apply to CUNY SEHP enrollees). Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose UnitedHealthcare if you have questions about your medical/surgical coverage.

Network Coverage

Some covered services received from a network provider are paid in full and others are subject to a copayment as described below.

The Plan does not guarantee that participating providers are available in all specialties or geographic locations.

To learn whether a provider participates, check with the provider directly, call UnitedHealthcare or visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. Click on Benefit Programs then NYSHIP Online, and choose your group, if prompted. Always confirm the provider's participation **before** you receive services.

Non-Network Coverage

Annual Deductible: \$100 per covered individual.

Coinsurance: Plan pays 80 percent of allowable amount for covered services after you meet the annual deductible.

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 testing and/or presurgical testing prior to an inpatient admission, radiology, anesthesiology and pathology.

Non-Network Coverage

Non-network benefits for covered services by a non-network provider.

Same as network coverage.

Outpatient Department of a Hospital

Network Coverage

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

For medical emergency: paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services when these services are not covered by Empire BlueCross BlueShield. Services of other physicians are considered under network coverage or non-network coverage as appropriate.

Non-Network Coverage

Non-network benefits for covered services by a non-network provider.

Same as network coverage.

Outpatient Department of a Hospital *continued*

Network Coverage

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.

Medically necessary physical therapy covered under the Managed Physical Medicine Program when not covered by Empire BlueCross BlueShield.

Non-Network Coverage

Plan pays up to 100 percent of allowable amount.

Non-network coverage under the Managed Physical Medicine Program when not covered by Empire BlueCross BlueShield.

Doctor's Office Visit, Office Surgery, Laboratory and Radiology

Network Coverage

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

The following types of office visits and services are paid in full and do not count toward the 15-visit per person limit: hemodialysis, chemotherapy and radiation therapy, well-child care, prenatal and postnatal office visits included in your provider's delivery charge. Prenatal and postnatal office visits that are not included in the delivery charge are subject to a \$10 copayment but do not count toward 15-visit per person limit.

Diagnostic laboratory tests and radiology not performed during an office visit, including interpretation of mammograms and analysis of cervical cytology screening, are covered subject to a \$10 copayment and do not count toward the 15-visit per person limit.

Contraceptive Drugs and Devices: \$10 copayment for required injections, insertion or other physician intervention provided during an office visit. (This copayment is in addition to your \$10 copayment for the office visit.)

Infertility Treatment: \$10 copayment for covered services such as artificial/intra-uterine insemination (see page 4) provided during an office visit.

You must have prior authorization for an MRI, and effective May 1, 2010, for an MRA, CT, PET or a Nuclear Medicine test (see page 2).

Outpatient surgery visits are not subject to copayment but count toward 15-visit per person limit.

Second Surgical Opinion: \$10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; counts toward 15-visit per person limit. One paid-in-full in-hospital consultation in each field per confinement.

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 or recurrence of cancer or a recommendation of course of treatment for cancer.

Non-Network Coverage

Non-network benefits for covered services received from non-participating providers or after the 15th visit to a participating provider.

Contraceptive Drugs and Devices: Same as network coverage, subject to deductible and coinsurance.

Infertility Treatment: Same as network coverage, subject to deductible and coinsurance.

Second Surgical Opinion: Same as network coverage, subject to deductible and coinsurance.

Second Opinion for Cancer Diagnosis: Same as network coverage.

Routine Health Exams

Network Coverage

Same as non-network coverage

Non-Network Coverage

Routine Physical: Up to \$60 reimbursement once every two years for active employee under age 40; annually for active employee over age 40. Not subject to copayment or 15-visit per person limit or deductible. There is no coverage for routine health exams for a spouse/domestic partner.

Allergy Care

Network Coverage

Office visits are covered subject to a \$10 copayment and count toward 15-visit per person limit. No separate copayment for basic skin tests done during office visit. Tests provided on different date or different location require a separate \$10 copayment, but do not count toward 15-visit per person limit.

Non-Network Coverage

Not covered

Routine Well-Child Care

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 limit.

Non-Network Coverage

Plan pays 100 percent of allowable amount. This benefit is not subject to deductible or coinsurance.

Mammograms and Cervical Cytology Screening

Network Coverage

\$10 copayment for mammography received from a network provider following recommended guidelines; \$10 copayment for cervical cytology screening. (Also see Hospital Outpatient, page 4.)

Non-Network Coverage

Plan pays 80 percent of allowable amount after you meet the annual deductible.

Pregnancy Termination

Network Coverage

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

Non-Network Coverage

Plan pays 80 percent of allowable amount after you meet the annual deductible.

Ambulatory Surgical Center

Network Coverage

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

Non-Network Coverage

Non-network benefits for covered services provided by non-participating surgical centers.

Ambulance Service

Network Coverage

Plan pays for local commercial ambulance charges for emergency transportation, subject to a \$15 copayment.

Emergency 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.

Non-Network Coverage

Emergency Transportation is covered the same as network coverage. This benefit is not subject to deductible or coinsurance.

Enteral Formulas; Modified Solid Food Products

Network Coverage

Same as non-network coverage

Non-Network Coverage

For prescribed enteral formulas, Plan pays up to 80 percent of allowable amount after you meet the annual deductible. For certain prescribed modified solid food products, Plan pays up to 80 percent of allowable amount after you meet the annual deductible, up to a total maximum reimbursement of \$3,000 per covered person per calendar year.

Managed Physical Medicine Program

administered by Managed Physical Network (MPN)

Chiropractic Treatment and Physical Therapy

Network Coverage *(When you use MPN)*

You pay a \$10 copayment for each office visit to an MPN provider. You pay an additional \$10 copayment for related radiology and diagnostic laboratory services billed by the MPN provider.

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

Physical Therapy: Up to 60 visits per diagnosis, if determined by MPN to be medically necessary.

Access to network benefits is guaranteed for chiropractic treatment and physical therapy. If there is not a network provider in your area, call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose UnitedHealthcare's MPN.

Non-Network Coverage *(When you don't use MPN)*

Annual Deductible: \$100 per covered individual. This deductible is separate from other plan deductibles.

Coinsurance: Plan pays up to 80 percent of allowable amount after you meet the annual deductible. Non-network benefits 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.

Program requirements apply even if another health insurance plan (including Medicare) is primary.

Home Care Advocacy Program (HCAP)

Home Care Services in Lieu of Hospitalization and Diabetic Equipment/Supplies



YOU MUST CALL for prior authorization

Network Coverage (When you use HCAP)

Home care services provided in lieu of hospitalization are paid in full for 365 visits. To receive this benefit, you must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose UnitedHealthcare's Home Care Advocacy Program (HCAP) for prior authorization.

Diabetic equipment and supplies, including insulin pumps and Medijectors are paid in full. To receive diabetic equipment and supplies, (except insulin pumps and Medijectors) call The Empire Plan Diabetic Supplies Pharmacy at **1-888-306-7337**. For insulin pumps and Medijectors you must use a network provider and call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose UnitedHealthcare's HCAP for prior authorization.

Non-Network Coverage (When you don't use HCAP)

Home care services are not covered unless precertified. If precertified, Plan pays 80 percent of allowable amount after you meet the annual deductible.

Diabetic equipment and supplies are covered up to 100 percent of allowable amount; not subject to deductible and coinsurance.

Program requirements apply even if another health insurance plan (including Medicare) is primary.

Mental Health and Substance Abuse Program



YOU MUST CALL for prior authorization

Precertification required. Call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth (administrator for UnitedHealthcare) before seeking any treatment for mental health or substance abuse, including alcoholism. OptumHealth's Clinical Referral Line is available 24 hours a day, every day of the year. By following the Program requirements for network coverage, you will receive the highest level of benefits. Access to network benefits is guaranteed.

In an emergency, OptumHealth will either arrange for an appropriate provider to call you back (usually within 30 minutes) or direct you to an appropriate facility for treatment. In a life-threatening situation, go to the emergency room. If you are admitted as an inpatient, you or someone acting on your behalf should call OptumHealth within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

Program requirements apply even if another health insurance plan (including Medicare) is primary.

Only treatment determined medically necessary by OptumHealth is covered.

If you are in treatment for mental health or alcohol/substance abuse at the time your NYSHIP SEHP coverage begins, please contact OptumHealth for help in making the transition to your NYSHIP coverage.

Facility Charges

Network Coverage

Inpatient Care in an Approved General Acute or Psychiatric Hospital or Clinic: Inpatient and Partial Hospitalization, Intensive Outpatient and Day Treatment Programs, 23 Hour Extended and 72 Hour Crisis Beds.

Copayment: \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays up to 100 percent of the network allowance after you pay the copayment.

Inpatient Care in a Residential Treatment Center, Group Home or Halfway House. Coverage for up to 30 days per person per year in an approved facility. \$200 copayment per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: Plan pays up to 80 percent of the network allowance after the copayment. You pay the remaining balance.

Hospital Emergency Room: You pay a \$25 copayment (waived if you are admitted as an inpatient directly from the emergency room).

Non-Network Coverage

Inpatient Care in an Approved General Acute or Psychiatric Hospital or Clinic: Inpatient and Partial Hospitalization, Intensive Outpatient and Day Treatment Programs, 23 Hour Extended and 72 Hour Crisis Beds.

Copayment: \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays 80 percent of OptumHealth's allowable amount after you pay the copayment. You pay the remaining balance.

Inpatient Care in a Residential Treatment Center, Group Home or Halfway House. Not a covered benefit.

Hospital Emergency Room: Same as network benefits.

Practitioners Visits

Network Coverage

Network coverage for up to 15 visits per person per calendar year to a network practitioner, subject to a \$10 copayment per visit. You pay the copayment. For visit 16 and beyond, non-network outpatient coverage applies.

Non-Network Coverage

Non-network benefits for covered services received from non-network practitioners or after the 15th visit to a network practitioner. Annual Deductible: \$100 per covered individual. Plan pays 80 percent of OptumHealth's allowable amount for covered services after the deductible. You pay the deductible and the remaining balance. The annual deductible is separate from the medical deductible.

Prescription Drug Program

Benefit Maximum

\$3,000 per person annual maximum for prescription drugs (network and non-network combined)

Copayments

You have the following copayments for drugs purchased from a participating pharmacy or through the mail service pharmacy.

Up to a 30-day supply from a participating retail pharmacy, mail service pharmacy or designated specialty pharmacy

Level 1 or Generic Drug	\$5
Level 2 or Preferred Brand-Name Drug.....	\$15
Level 3 or Non-Preferred Brand-Name Drug.....	\$30*

31- to 90-day supply through the mail service pharmacy or designated specialty pharmacy

Level 1 or Generic Drug	\$5
Level 2 or Preferred Brand-Name Drug	\$20
Level 3 or Non-Preferred Brand-Name Drug	\$55**

When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the non-preferred brand-name copayment plus the difference in cost between the brand-name drug and the generic equivalent, not to exceed the full retail cost of the drug. Certain drugs are excluded from this requirement. You pay only the applicable copayment for these brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid and Tegretol. You have coverage for prescriptions for more than a 30-day supply through the mail service pharmacy or designated specialty pharmacy. Oral contraceptives are covered as brand or generic. Prescriptions may be refilled for up to one year.

Note: At certain SUNY Campus Student Health Centers, SUNY SEHP enrollees and/or their 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.)

*\$40 Copayment effective September 1, 2010

**\$65 Copayment effective September 1, 2010

Mail Service Pharmacy

You may fill your prescription through the mail service or designated specialty pharmacy by using a mail order form. To obtain a mail order form, call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Prescription Drug Program, or download a copy from the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. Click on Benefit Programs then NYSHIP Online, and choose your group, if prompted. Prescription refills may be ordered by phone at the above number, or online by accessing the NYSHIP Online web site as directed above, selecting Find a Provider and scrolling down to The Empire Plan Prescription Drug Program web site link.

Non-Participating Pharmacy

If you do not use your benefit card at a participating or non-participating pharmacy and pay the full retail cost of your prescription, you must submit a claim for reimbursement to Medco, P.O. Box 14711, Lexington, KY, 40512. 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 participating pharmacy for that prescription. 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 participating pharmacy for filling the prescription with that drug's generic equivalent. In most cases, you will not be reimbursed the total amount you paid for the prescription.

Specialty Pharmacy Program

The Specialty Pharmacy Program is scheduled to be implemented effective April 1, 2010. Under this Program, specialty drugs will be covered through a designated Specialty Pharmacy subject to the applicable mail service prescription drug copayment. Prior authorization is required for some specialty drugs.

Flexible Formulary

Effective April 1, 2010, there is a flexible formulary for your Empire Plan Prescription Drug Program. 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 a small number of drugs;
- placing brand-name drugs that provide the best value to the Plan on the Flexible Formulary Drug List; and
- applying the highest copayment to non-preferred brand-name drugs that provide no clinical advantage over generic or preferred brand-name drug alternatives.

Prescription drugs excluded or limited in quantity under The Empire Plan Prescription Drug Program are not subject to exception.

Instant Rebate for Omeprazole (generic Prilosec)

For a limited time only, The Empire Plan Prescription Drug Program will offer an instant rebate of your full copayment for omeprazole, the generic version of Prilosec (the original "purple pill"). This medication is a proton pump inhibitor used in the treatment of peptic ulcers, gastroesophageal reflux disease (GERD) and other gastrointestinal symptoms.

The instant rebate will apply to all omeprazole prescriptions filled at a participating pharmacy between April 1, 2010 and July 31, 2010. To receive your rebate (zero copayment), simply present your prescription to a retail pharmacy or send it to the mail service pharmacy. After July 31, 2010, you will pay the applicable generic copayment (\$5) for subsequent refills. If you have questions about this rebate or your drug benefit, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose The Empire Plan Prescription Drug Program.

Prior Authorization Required

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

- | | | | | |
|-------------|--------------------|------------|--------------|---------------------|
| • Adcirca | • Epogen/Procrit | • Intron-A | • Peg-Intron | • Synagis |
| • Amevive | • Extavia | • Iplex | • Provigil | • Tracleer |
| • Aranesp | • Flolan | • Kineret | • Rebif | • Tysabri |
| • Avonex | • Forteo | • Kuvan | • Remicade | • Tyvaso |
| • Betaseron | • Growth Hormones | • Lamisil | • Remodulin | • Ventavis |
| • Botox | • Humira | • Letairis | • Revatio | • Weight Loss Drugs |
| • Cimzia | • Immune Globulins | • Myobloc | • Roferon-A | • Xolair |
| • Copaxone | • Increlex | • Nuvigil | • Simponi | • Xyrem |
| • Dysport | • Infergen | • Orencia | • Sporanox | |
| • Enbrel | | • Pegasys | • Stelara | |

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 \$100 will also require prior authorization under this Program. The above list of drugs is subject to change as drugs are approved by the Food and Drug Administration and introduced into the market. For the most current Empire Plan drug list, prior authorization requirements, or the current list of drugs requiring authorization, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose The Empire Plan Prescription Drug Program. Or, go to the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to NYSHIP Online. Select Find a Provider and scroll to Medco and click The Empire Plan: Drugs that Require Prior Authorization.

SEHP Dental Care Benefit Summary

Dental Program

Each visit is subject to a \$20 copayment, up to two visits per 12-month period when you visit a participating provider in the SEHP dental program for covered services.

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 participating provider in the SEHP dental program.

Participating Provider: To locate a participating provider in the SEHP dental program, you can link to the GHI web site by accessing <https://www.cs.state.ny.us>. Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. Select Other Benefits, then Dental or call **1-800-947-0101**.

GHI's Discounted Dental Access Program

When you enroll in the SEHP dental program you are automatically enrolled in GHI's Discounted Dental Access Program. If you utilize a provider who participates in the GHI 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 GHI Discounted Dental Access Program, please call GHI's Dedicated Customer Service Center at **1-800-947-0101** for a list or a CD-ROM identifying GHI Discounted Dental Access Program participating providers.

Administration

For **Eligibility** questions, please contact the Health Benefits Administrator (HBA) on your campus.

For **Customer Service**, please contact GHI's Dedicated Customer Services Center at **1-800-947-0101** after you have enrolled.

Correspondence: Please direct your correspondence to:

GHI, Attn: NYS Dental Customer Service, P.O. Box 12365, Albany, NY 12212-2365

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

ID Card: If you go to a provider who participates in the SEHP dental program and/or the GHI Discounted Dental Access Program, present your GHI identification card before you receive services.

SEHP Vision Care Benefit Summary

Network Benefits

A routine eye examination (subject to a \$10 copayment) is covered 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 non-participating provider.

To Confirm Eligibility or Locate a Network Provider

Contact EyeMed, the plan administrator, at **1-877-226-1412** or link to their web site by accessing <https://www.cs.state.ny.us>. Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. Select Other Benefits, then Vision.

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 EyeMed.
- 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, be sure to pay the provider your \$10 eye examination copayment.

Exclusions

Services not covered under the SEHP include, but are not limited to, the following:

- expenses in excess of \$100,000 (non-network benefits); in excess of \$350,000 (network and non-network combined); and prescription drugs in excess of \$3,000 (network and non-network combined);
- care that is not medically necessary;
- experimental or investigative procedures;
- custodial care;
- cosmetic surgery;
- routine foot care;
- sex change;
- durable medical equipment and supplies unless provided under the Home Care Advocacy Program (HCAP);
- prosthetics (except breast prostheses, which are paid in full);
- orthotics;
- TMJ treatment (except when caused by a medical condition);
- hearing aids;
- weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity);
- adult immunizations (except as part of a covered routine physical);
- skilled nursing facility care including rehabilitation;
- allergy extracts and injections;
- inpatient alcohol and substance abuse rehabilitation;
- psychological testing and evaluation and outpatient psychiatric second opinion;
- drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease;
- reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intra-uterine insemination and other services for which coverage is mandated by New York State Insurance Law); cloning;
- cardiac rehabilitation;
- occupational therapy;
- speech therapy.

Benefits On The Web

You'll find NYSHIP Online, the Employee Benefits Division home page, on the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. Click on Benefit Programs, then NYSHIP Online.

On your first visit, you will be asked what group and benefit plan you have. Thereafter, you will not be prompted to enter this information if you have your cookies enabled. Cookies are simple text files stored on your web browser to provide a way to identify and distinguish the users of this site. If enabled, cookies will customize your visit to the site and group-specific pages will then display each time you visit unless you select Change Your Group on a toolbar near the top left of the page.

Without enabling cookies, when you select your group and health benefits plan to view your group-specific health insurance benefits, you will be required to reselect your group and benefits plan each time you navigate the health benefits section of the web site or revisit the site from the same computer at another time.

NYSHIP Online is a complete resource for your health insurance benefits, including up-to-date publications, and links to NYSHIP carrier web sites. These web sites include the most current list of providers, and the information is continually updated. You can search by location, specialty or name. Announcements, an event calendar, prescription drug information and handy contact information are only a click or two away.

The *NYSHIP SEHP Summary of Benefits* 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.



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

518-457-5754 (Albany area) 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
<https://www.cs.state.ny.us>

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

State of New York
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
<https://www.cs.state.ny.us>

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

SEHP Summary of Benefits – January 2010

**Please do not send mail
or correspondence to
the return address
above. See boxed
address on page 15.**

It is the policy of the State of New York 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 the Department of Civil Service web site (<https://www.cs.state.ny.us>). Check the web site 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 agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 (Albany area) 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. Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. Plan covers services required as a result of such examinations. Plan covers services required as a result of an acute gynecologic condition. 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 2.

Annual Notice of Mastectomy and Reconstructive Surgery Benefits

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. Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery of the other breast to produce a symmetrical appearance. Plan also covers treatment for complications of mastectomy, including lymphedema and breast prostheses.

Benefits Management Program requirements apply. See page 2.