

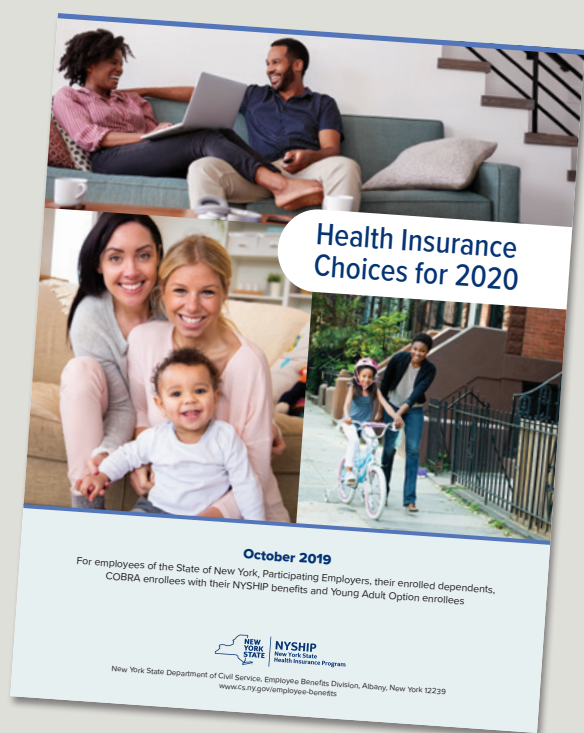


# Health Insurance Choices for 2020

## Supplement

This flyer is a companion document to the *Health Insurance Choices for 2020* booklet. It explains your benefits as a NYSHIP enrollee in a negotiating unit that does not have an agreement/award with New York State effective at the time that this document was printed.

Please refer to this document in place of pages 16-25 in *Choices* for information on your Empire Plan benefits.



## October 2019

For employees of the State of New York in the Agency Police Services Unit (APSU) represented by the Police Benevolent Association of New York State (PBANYS) or represented by Council 82 (C-82) or the Public Employees Federation (PEF), their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees



**NYSHIP**  
New York State  
Health Insurance Program

# The Empire Plan NYSHIP Code #001

Empire Plan benefits are available worldwide, and the Plan gives you the freedom to choose a participating or nonparticipating provider or facility. This section summarizes benefits available under each portion of The Empire Plan as of January 1, 2020.<sup>1</sup> You may also visit [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for additional information on the following programs.

## Medical/Surgical Program

### UnitedHealthcare

Medical and surgical coverage through:

- **Participating Provider Program** – More than 300,000 physicians and other providers participate; certain services are subject to a \$20 copayment.
- **Basic Medical Program** – If you use a nonparticipating provider, the Program considers up to 80 percent of usual and customary charges for covered services after the combined annual deductible is met. After the combined annual coinsurance maximum is met, the Plan considers up to 100 percent of usual and customary charges for covered services. See Cost Sharing (beginning on page 4) for additional information.
- **Basic Medical Provider Discount Program** – If you are Empire Plan primary and use a nonparticipating provider who is part of the Empire Plan MultiPlan group, your out-of-pocket costs may be lower (see page 5).

**Home Care Advocacy Program (HCAP)** – Paid-in-full benefits for home care, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes. (Diabetic shoes have an annual maximum benefit of \$500.) Prior authorization is required. Guaranteed access to network benefits nationwide. Limited non-network benefits available (see the *Empire Plan Certificate* for details).

**Managed Physical Medicine Program** – Chiropractic treatment, physical therapy and occupational therapy through a Managed Physical Network (MPN) provider are subject to a \$20 copayment. Unlimited network benefits when medically necessary. Guaranteed access to network benefits nationwide. Non-network benefits available.

Under the **Benefits Management Program**, you must call the Medical/Surgical Program for Prospective Procedure Review before an elective (scheduled) magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT) scan, positron emission tomography (PET) scan or nuclear medicine test, unless you are having the test as an inpatient in a hospital (see the *Empire Plan Certificate* for details).

When arranged by the Medical/Surgical Program, a voluntary, paid-in-full specialist consultant evaluation is available. Voluntary outpatient medical case management is available to help coordinate services for catastrophic and complex cases.

## Hospital Program

### Empire BlueCross

The following benefit levels apply for covered services received at a BlueCross and BlueShield Association BlueCard® PPO **network hospital**:

- Inpatient hospital stays are covered at no cost to you.
- Outpatient hospital and emergency care are subject to network copayments.
- Anesthesiology, pathology and radiology provider charges for covered hospital services are paid in full under the Medical/Surgical Program (if The Empire Plan provides your primary coverage).
- Certain covered outpatient hospital services provided at network hospital extension clinics are subject to outpatient hospital copayments.
- Except as noted above, physician charges received in a hospital setting will be paid in full if the provider is a participating provider under the Medical/Surgical Program. Physician charges for covered services received from a non-network provider will be paid in accordance with the Basic Medical portion of the Medical/Surgical Program.

<sup>1</sup> These benefits are subject to medical necessity and to limitations and exclusions described in the *Empire Plan Certificate* and *Certificate Amendments*.

If you are an Empire Plan-primary enrollee,<sup>2</sup> you will be subject to 10 percent coinsurance for inpatient stays at a **non-network hospital**. For outpatient services received at a non-network hospital, you will be subject to the greater of 10 percent coinsurance or \$75 per visit. In either scenario, expenses will be reimbursed only after the applicable combined annual coinsurance maximum threshold (see page 5) has been reached.

The Empire Plan will approve network benefits for hospital services received at a non-network facility if:

- Your hospital care is emergency or urgent
- No network facility can provide the medically necessary services
- You do not have access to a network facility within 30 miles of your residence
- Another insurer or Medicare provides your primary coverage (pays first)

### **Preadmission Certification Requirements**

Under the Benefits Management Program, if The Empire Plan is your primary coverage, you must call the Hospital Program for certification of any of the following inpatient stays:

- Before a maternity or scheduled (nonemergency) hospital admission
- Within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission
- Before admission or transfer to a skilled nursing facility

If you do not follow the preadmission certification requirement for the Hospital Program, you must pay:

- A \$200 hospital penalty if it is determined any portion was medically necessary; and
- All charges for any day's care determined not to be medically necessary.

Voluntary inpatient medical case management is available to help coordinate services for catastrophic and complex cases.

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

<sup>3</sup> You are responsible for ensuring that MHSAs Program certification is received for care obtained from a non-network practitioner or facility.

## **Mental Health and Substance Abuse Program**

### **Beacon Health Options Inc.**

The Mental Health and Substance Abuse (MHSAs) Program offers both network and non-network benefits.

### **Network Benefits**

(unlimited when medically necessary)

If you call the MHSAs Program before you receive services and follow their requirements, you receive:

- Inpatient services, paid in full
- Crisis intervention, paid in full for up to three visits per crisis; after the third visit, the \$20 copayment per visit applies
- Outpatient services, including office visits, home-based or telephone counseling and nurse practitioner services, for a \$20 copayment per visit
- Intensive Outpatient Program (IOP) with an approved provider for mental health or substance use treatment for a \$20 copayment per day

### **Non-Network Benefits<sup>3</sup>**

(unlimited when medically necessary)

The following applies if you do **NOT** follow the requirements for network coverage.

- For Practitioner Services: The MHSAs Program will consider up to 80 percent of usual and customary charges for covered outpatient practitioner services after you meet the combined annual deductible per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined. After the combined annual coinsurance maximum is reached per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined, the Program pays up to 100 percent of usual and customary charges for covered services (see page 5).
- For Approved Facility Services: You are responsible for 10 percent of covered billed charges up to the combined annual coinsurance maximum per

enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined. After the coinsurance maximum is met, the Program pays 100 percent of billed charges for covered services (see page 5).

- Outpatient treatment sessions for family members of an individual being treated for alcohol or substance use are covered for a maximum of 20 visits per year for all family members combined.

## Empire Plan Cost Sharing

### Plan Providers

Under The Empire Plan, benefits are available for covered services when you use a participating or nonparticipating provider. However, your share of the cost of covered services depends on whether the provider you use participates in the Plan. You receive the maximum plan benefits when you use participating providers. For more information, read *Reporting On Network Benefits*. You can find this publication at [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) or ask your HBA for a copy.

**If you use an Empire Plan participating or network provider or facility,** you pay a copayment for certain services. Some services are covered at no cost to you. The provider or facility files the claim and is reimbursed by The Empire Plan.

You are guaranteed access to network benefits for certain services when you contact the program before receiving services and follow program requirements for:

- Mental Health and Substance Abuse (MHSA) Program services
- Managed Physical Medicine Program services (physical therapy, chiropractic care and occupational therapy)
- Home Care Advocacy Program (HCAP) services (including durable medical equipment)

**If you use a nonparticipating provider or non-network facility,** benefits for covered services are subject to a deductible and/or coinsurance.

### 2020 Annual Maximum Out-of-Pocket Limit

Your maximum out-of-pocket expenses for in-network covered services will be \$5,300 for Individual coverage and \$10,600 for Family coverage for Hospital, Medical/Surgical and MHSA Programs, combined. Once you reach the limit, you will have no additional copayments.

### Combined Annual Deductible

For Medical/Surgical and MHSA Program services received from a nonparticipating provider or non-network facility, The Empire Plan has a combined annual deductible that must be met before covered services under the Basic Medical Program and non-network expenses under both the HCAP and MHSA Programs can be reimbursed. See the table on page 5 for 2020 combined annual deductible amounts. The Managed Physical Medicine Program has a separate \$250 deductible per enrollee, \$250 per enrolled spouse/domestic partner and \$250 per all dependent children combined that is not included in the combined annual deductible.

After you satisfy the combined annual deductible, The Empire Plan considers 80 percent of the usual and customary charge for the Basic Medical Program and non-network practitioner services for the MHSA Program, 50 percent of the network allowance for covered services for non-network HCAP services and 90 percent of the billed charges for covered services for non-network approved facility services for the MHSA Program. You are responsible for the remaining 20 percent coinsurance and all charges in excess of the usual and customary charge for Basic Medical Program and non-network practitioner services, 10 percent for non-network MHSA-approved facility services and the remaining 50 percent of the network allowance for covered, non-network HCAP services.

### Combined Annual Coinsurance Maximum

The Empire Plan has a combined annual coinsurance maximum that must be met before covered services under the Basic Medical Program and non-network expenses under both the HCAP and MHSA Programs can be reimbursed. See the table below for 2020 combined annual coinsurance maximum amounts.

After you reach the combined annual coinsurance maximum, you will be reimbursed up to 100 percent of covered charges under the Hospital Program and 100 percent of the usual and customary charges for services covered under the Basic Medical Program and MHSA Program. You are responsible for paying the provider and will be reimbursed by the Plan for covered charges. You are also responsible for paying all charges in excess of the usual and customary charge.

The combined annual coinsurance maximum will be shared among the Basic Medical Program and non-network coverage under the Hospital Program and MHSA Program. The Managed Physical Medicine Program and HCAP do not have a coinsurance maximum.

### Basic Medical Provider Discount Program

If you are Empire Plan primary, The Empire Plan also includes a program to reduce your out-of-pocket costs when you use a nonparticipating provider. The Empire Plan Basic Medical Provider Discount Program offers discounts from certain physicians and providers who are not part of The Empire Plan participating provider network. These providers are part of the nationwide MultiPlan group, a provider organization contracted with UnitedHealthcare. Empire Plan Basic Medical Program provisions apply, and you must meet the combined annual deductible.

Providers in the Basic Medical Provider Discount Program accept a discounted fee for covered services. Your 20 percent coinsurance is based on the lower of the discounted fee or the usual and customary charge. Under this Program, the provider submits your claims, and UnitedHealthcare pays The Empire Plan portion of the provider fee directly to the provider if the services qualify for the Basic Medical Provider Discount Program. Your explanation of benefits, which details claims payments, shows the discounted amount applied to billed charges.

2020 Combined Annual Deductible and Annual Coinsurance Maximum Amounts		
Employees who are in the APSU represented by PBANYS; or represented by C-82 or PEF	Combined Annual Deductible	Combined Annual Coinsurance Maximum
Enrollee	\$1,000	\$3,000
Enrolled spouse/domestic partner	\$1,000	\$3,000
Dependent children combined	\$1,000	\$3,000
Reduced amount for enrollees* represented by PEF in titles equated to Salary Grade 6 and below	\$500	\$1,500

\* And each deductible or coinsurance maximum amount for an enrolled spouse/domestic partner and dependent children combined.

To find a provider in the Empire Plan Basic Medical Provider Discount Program, ask if the provider is an Empire Plan MultiPlan provider or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447), choose the Medical/Surgical Program and ask a representative for help. You can also go to [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits). Select your group and plan, if prompted, and then Find a Provider.

## Prescription Drug Program

### CVS Caremark

*The Prescription Drug Program does not apply to those who have drug coverage through a union Employee Benefit Fund.*

- When you use a network pharmacy, the mail service pharmacy or the specialty pharmacy for a 1- to 30-day supply of a covered drug, you pay a \$5 copayment for Level 1 or most generic drugs; a \$25 copayment for Level 2, preferred drugs or compound drugs; and a \$45 copayment for Level 3, certain generic drugs or non-preferred drugs.
- For a 31- to 90-day supply of a covered drug through a network pharmacy, you pay a \$10 copayment for Level 1 or most generic drugs; a \$50 copayment for Level 2, preferred drugs or compound drugs; and a \$90 copayment for Level 3, certain generic drugs or non-preferred drugs.
- For a 31- to 90-day supply of a covered drug through the mail service pharmacy or the specialty pharmacy, you pay a \$5 copayment for Level 1 or most generic drugs; a \$50 copayment for Level 2, preferred drugs or compound drugs; and a \$90 copayment for Level 3, certain generic drugs or non-preferred drugs.
- When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 or non-preferred copayment, plus the difference in cost between the brand-name drug and the generic equivalent (or “ancillary charge”), not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Flexible Formulary. Exceptions apply. Please contact the Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP (1-877-769-7447) for more information.

- The Empire Plan has a flexible formulary that excludes certain prescription drugs from coverage.
- Prior authorization is required for certain drugs.
- Oral chemotherapy drugs for the treatment of cancer do not require a copayment.
- Tamoxifen and Raloxifene, when prescribed for the primary prevention of breast cancer, do not require a copayment. In addition, generic oral contraceptive drugs/devices or brand-name drugs/devices without a generic equivalent (single-source brand-name drugs/devices) do not require a copayment. The copayment waivers for these drugs will only be provided if the drug is filled at a network pharmacy.
- Certain preventive adult vaccines, when administered at a pharmacy that participates in the CVS Caremark National Vaccine Network, do not require a copayment.
- A pharmacist is available 24 hours a day, seven days a week to answer questions about your prescriptions.
- You can use a non-network pharmacy or pay out of pocket at a network pharmacy (instead of using your Empire Plan Benefit Card) and submit a claim form for reimbursement. In almost all cases, you will not be reimbursed the total amount you paid for the prescription and your out-of-pocket expenses may exceed the usual copayment amount. To reduce your out-of-pocket expenses, use your Empire Plan Benefit Card whenever possible.

See the *Empire Plan Certificate* or contact the Plan for more information.

### 2020 Annual Maximum Out-of-Pocket Limit\*

Your annual maximum out-of-pocket expenses for covered drugs received from a network pharmacy will be \$2,850 for Individual coverage and \$5,700 for Family coverage. Once you reach the limit, you will have no additional copayments for prescription drugs.

\* The annual maximum out-of-pocket limit does not apply to Empire Plan Medicare Rx.

## Specialty Pharmacy

CVS Caremark Specialty Pharmacy is the designated pharmacy for The Empire Plan Specialty Pharmacy Program. The Program provides enhanced services to individuals using specialty drugs (such as those used to treat complex conditions and those that require special handling, special administration or intensive patient monitoring). The complete list of specialty drugs included in the Specialty Pharmacy Program is available on NYSHIP Online. Go to [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) and choose your group and plan, if prompted. Select Using Your Benefits and then Specialty Pharmacy Drug List.

The Program provides enrollees with enhanced services that include disease and drug education; compliance, side effect and safety management; expedited, scheduled delivery of medications at no additional charge; refill reminder calls; and all necessary supplies (such as needles and syringes) applicable to the medication.

Under the Specialty Pharmacy Program, you are covered for an initial 30-day fill of most specialty medications at a retail pharmacy, but all subsequent fills must be obtained through the designated specialty pharmacy. When CVS Caremark dispenses a specialty medication, the applicable mail service copayment is charged. To get started with CVS Caremark Specialty Pharmacy, request refills or speak to a specialty-trained pharmacist or nurse, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447). Choose the Prescription Drug Program and ask to speak with Specialty Customer Care.

## Medicare-primary enrollees and dependents:

If you are or will be Medicare primary in 2020, ask your HBA for a copy of *2020 Choices for Retirees* for information about your coverage under Empire Plan Medicare Rx, a Medicare Part D prescription drug program.

## The Empire Plan NurseLine<sup>SM</sup>

Call The Empire Plan and press or say 5 for the NurseLine<sup>SM</sup> for health information and support.

Representatives are available 24 hours a day, seven days a week.

## Contact The Empire Plan

For additional information or questions on any of the benefits described here, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the applicable program.

### Teletypewriter (TTY) Numbers

These numbers are available to callers who use a TTY device because of a disability and are all toll free.

#### Medical/Surgical Program

TTY only:.....1-888-697-9054

#### Hospital Program

TTY only:.....1-800-241-6894

#### Mental Health and Substance Abuse Program

TTY only:.....1-855-643-1476

#### Prescription Drug Program

TTY only:.....711

## The Empire Plan

For employees of the State of New York who are represented by C-82, PBANYS or PEF; and their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees.

Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Office Visits<sup>2</sup></b>		\$20 per visit	Basic Medical <sup>3</sup>
<b>Specialty Office Visits<sup>2</sup></b>		\$20 per visit	Basic Medical <sup>3</sup>
<b>Diagnostic Services:<sup>2</sup></b>			
Radiology	\$40 per outpatient visit	\$20 per visit	Basic Medical <sup>3</sup>
Lab Tests	\$40 per outpatient visit	\$20 per visit	Basic Medical <sup>3</sup>
Pathology	No copayment	\$20 per visit	Basic Medical <sup>3</sup>
EKG/EEG	\$40 per outpatient visit	\$20 per visit	Basic Medical <sup>3</sup>
Radiation, Chemotherapy, Dialysis	No copayment	No copayment	Basic Medical <sup>3</sup>
<b>Women's Health Care/ Reproductive Health:<sup>2</sup></b>			
Screenings and Maternity-Related Lab Tests	\$40 per outpatient visit	\$20 per visit	Basic Medical <sup>3</sup>
Mammograms	No copayment	No copayment	Basic Medical <sup>3</sup>
Pre/Postnatal Visits and Well-Woman Exams		\$20 per visit	Basic Medical <sup>3</sup>
Bone Density Tests	\$40 per outpatient visit	\$20 per visit	Basic Medical <sup>3</sup>
Breastfeeding Services and Equipment		No copayment for pre/postnatal counseling and equipment purchase from a participating provider; one double-electric breast pump per birth	
External Mastectomy Protheses		No network benefit. See nonparticipating provider.	Paid-in-full benefit for one single or double prosthesis per calendar year under Basic Medical, not subject to deductible or coinsurance <sup>4</sup>
<b>Family Planning Services<sup>2</sup></b>		\$20 per visit	Basic Medical <sup>3</sup>
<b>Infertility Services</b>	\$40 per outpatient visit <sup>5</sup>	\$20 per visit; no copayment at designated Centers of Excellence <sup>5</sup>	Basic Medical <sup>3</sup>



Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Contraceptive Drugs and Devices</b>		No copayment for certain FDA-approved oral contraception methods and counseling	Basic Medical <sup>3</sup>
<b>Inpatient Hospital Surgery</b>	No copayment <sup>6</sup>	No copayment	Basic Medical <sup>3</sup>
<b>Outpatient Surgery</b>	\$60 per visit	\$20 per visit <sup>7</sup>	Basic Medical <sup>3</sup>
<b>Emergency Department</b>	\$70 per visit <sup>8</sup>	No copayment	Basic Medical <sup>3,9</sup>
<b>Urgent Care</b>	\$40 per outpatient visit <sup>10</sup>	\$20 per visit	Basic Medical <sup>3</sup>
<b>Ambulance</b>	No copayment <sup>11</sup>	\$35 per trip <sup>12</sup>	\$35 per trip <sup>12</sup>
<b>Mental Health Practitioner Services</b>		\$20 per visit	Applicable annual deductible, 80% of usual and customary; after applicable coinsurance max, 100% of usual and customary (see pages 4-5 for details)
<b>Approved Facility Mental Health Services</b>		No copayment	90% of billed charges; after applicable coinsurance max, covered in full (see pages 4-5 for details)

<sup>1</sup> Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical/Surgical Program. Non-network hospital coverage provided subject to coinsurance (see pages 2–3).

<sup>2</sup> Copayment waived for preventive services under the PPACA. See [www.hhs.gov/healthcare/rights/preventive-care](http://www.hhs.gov/healthcare/rights/preventive-care) or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

<sup>3</sup> See Cost Sharing (beginning on page 4) for Basic Medical information.

<sup>4</sup> Any single mastectomy prosthesis costing \$1,000 or more requires prior approval.

<sup>5</sup> Certain qualified procedures require precertification and are subject to a \$50,000 lifetime allowance.

<sup>6</sup> Preadmission certification required.

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

<sup>8</sup> Copayment waived if admitted.

<sup>9</sup> Attending emergency department physicians and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and/or pathology services are paid in full. Other providers are considered under the Basic Medical Program and are not subject to deductible or coinsurance.

<sup>10</sup> At a hospital-owned urgent care facility only.

<sup>11</sup> If service is provided by admitting hospital.

<sup>12</sup> Ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and the type of ambulance transportation is required because of an emergency situation.

## The Empire Plan

Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Outpatient Drug/Alcohol Rehabilitation</b>		\$20 per day to approved Intensive Outpatient Program	Applicable annual deductible, 80% of usual and customary; after applicable coinsurance max, 100% of usual and customary (see pages 4-5 for details)
<b>Inpatient Drug/Alcohol Rehabilitation</b>		No copayment	90% of billed charges; after applicable coinsurance max, covered in full (see pages 4-5 for details)
<b>Durable Medical Equipment</b>		No copayment (HCAP)	50% of network allowance (see the <i>Empire Plan Certificate</i> )
<b>Prosthetics</b>		No copayment <sup>13</sup>	Basic Medical <sup>3, 13</sup> \$1,500 lifetime maximum benefit for prosthetic wigs not subject to deductible or coinsurance
<b>Orthotic Devices</b>		No copayment <sup>13</sup>	Basic Medical <sup>3, 13</sup>
<b>Rehabilitative Care</b> (not covered in a skilled nursing facility if Medicare primary)	No copayment as an inpatient; \$20 per visit for outpatient physical therapy following related surgery or hospitalization <sup>14</sup>	Physical or occupational therapy \$20 per visit (MPN)  Speech therapy \$20 per visit	\$250 annual deductible, 50% of network allowance  Basic Medical <sup>3</sup>
<b>Diabetic Supplies</b>		No copayment (HCAP)	50% of network allowance (see the <i>Empire Plan Certificate</i> )
<b>Insulin and Oral Agents</b> (covered under the Prescription Drug Program, subject to drug copayment)			
<b>Diabetic Shoes</b>		\$500 annual maximum benefit	75% of network allowance up to an annual maximum benefit of \$500 (see the <i>Empire Plan Certificate</i> )
<b>Hospice</b>	No copayment, no limit		10% of billed charges up to the combined annual coinsurance maximum
<b>Skilled Nursing Facility<sup>15, 16</sup></b>	No copayment		10% of billed charges up to the combined annual coinsurance maximum

Benefits	Network Hospital Benefits <sup>1,2</sup>	Participating Provider <sup>2</sup>	Nonparticipating Provider
<b>Prescription Drugs</b> (see pages 6-7)			
Specialty Drugs (see page 7)			
<b>Additional Benefits:</b>			
Dental (preventive)		Not covered	Not covered
Vision (routine only)		Not covered	Not covered
Hearing Aids		No network benefit. See nonparticipating provider.	Up to \$1,500 per aid per ear every 4 years (every 2 years for children) if medically necessary
Annual Out-of-Pocket Maximum	Individual coverage: \$2,850 for the Prescription Drug Program. <sup>16</sup> \$5,300 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Abuse Programs. Family coverage: \$5,700 for the Prescription Drug Program. <sup>16</sup> \$10,600 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Abuse Programs.		Not available
Out-of-Area Benefit	Benefits for covered services are available worldwide.		
24-hour NurseLine <sup>SM</sup> for health information and support at 1-877-7-NYSHIP (1-877-769-7447); press or say Option 5.			
Voluntary disease management programs available for conditions such as asthma, attention deficit hyperactivity disorder (ADHD), cardiovascular disease, chronic kidney disease (CKD), chronic obstructive pulmonary disease, congestive heart failure, depression, diabetes and eating disorders.			
Diabetes education centers for enrollees who have a diagnosis of diabetes.			
For more information regarding covered vaccines, tests and screenings, see the <i>Empire Plan Preventive Care Coverage Chart</i> on NYSHIP Online under Publications or visit <a href="http://www.hhs.gov/healthcare/rights/preventive-care">www.hhs.gov/healthcare/rights/preventive-care</a> .			
<sup>1</sup> Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical/Surgical Program. Non-network hospital coverage provided subject to coinsurance (see pages 2–3). <sup>2</sup> Copayment waived for preventive services under the PPACA. See <a href="http://www.hhs.gov/healthcare/rights/preventive-care">www.hhs.gov/healthcare/rights/preventive-care</a> or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance. <sup>3</sup> See Cost Sharing (beginning on page 4) for Basic Medical information.		<sup>13</sup> Benefit paid up to cost of device meeting individual’s functional need. <sup>14</sup> Physical therapy must begin within six months of the related surgery or hospitalization and be completed within 365 days of the related surgery or hospitalization. <sup>15</sup> Up to 365 benefit days; Benefits Management Program provisions apply. <sup>16</sup> Does not apply to Medicare-primary enrollees.	



**NYSHIP**  
New York State  
Health Insurance Program

### ***2020 Health Insurance Choices Supplement – October 2019***

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](http://www.cs.ny.gov/employee-benefits). Visit NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS agency websites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator. COBRA and Young Adult Option enrollees, contact the Employee Benefits Division.