



# AT A GLANCE

## PA Excelsior | Participating Agencies

For Employees, Retirees, Vestees and Dependent Survivors enrolled in the Excelsior Plan through Participating Agencies and their enrolled Dependents; and for COBRA enrollees and Young Adult Option Enrollees with their Excelsior Plan benefits

This guide briefly describes Excelsior Plan benefits. For information regarding your New York State Health Insurance Program (NYSHIP) eligibility or enrollment, contact your agency Health Benefits Administrator. If you have questions regarding specific benefits or claims, contact the appropriate Plan administrator (see page 19).

### **THIS PUBLICATION ALSO INCLUDES:**

- 2018 Empire Plan Preventive Care Coverage Chart
- 2018 Excelsior Plan Drug List
- Out-of-Network Reimbursement Disclosures



**The Empire  
Plan**

New York State Department of Civil Service  
Employee Benefits Division, Albany, NY 12239  
[www.cs.ny.gov](http://www.cs.ny.gov)

**January 1, 2018**

## WHAT'S NEW

- **In-network Out-of-Pocket Limit** – For 2018, the maximum out-of-pocket limit for covered, in-network services under the Excelsior Plan is \$7,350 for Individual coverage and \$14,700 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. See page 3 for more information.
- **Breast Cancer Detection Coverage** – All in-network diagnostic and screening mammograms, breast ultrasounds and magnetic resonance imaging are covered with no copayment, regardless of an individual's age, sex or medical history, when recommended by the treating provider. This includes in-network 3-D mammograms (breast tomosynthesis), effective February 20, 2017. Medically necessary non-network 3-D mammograms are also covered but are subject to deductible and coinsurance. For questions regarding coverage, call the Medical/Surgical Program.
- **2018 Excelsior Plan Drug List** – The quarterly update lists the most commonly prescribed generic and brand-name drugs included in the 2018 Excelsior Plan Drug List and newly excluded drugs with 2018 Excelsior Plan Drug List alternatives.

## Quick Reference

**The Excelsior Plan is a comprehensive health insurance plan for New York's public employees and their families. The Plan has four main parts:**

### **Hospital Program**

**administered by Empire BlueCross BlueShield**

Provides coverage for inpatient and outpatient services provided by a hospital or skilled nursing facility and hospice care. Includes the Center of Excellence for Transplants Program. Also provides inpatient Benefits Management Program services, including preadmission certification of hospital admissions and admission or transfer to a skilled nursing facility, concurrent reviews, discharge planning, inpatient medical case management and the Future Moms Program.

### **Medical/Surgical Program**

**administered by UnitedHealthcare**

Provides coverage for medical services, such as office visits, convenience care clinics, surgery and diagnostic testing under the Participating Provider, Basic Medical and Basic Medical Provider Discount Programs. Coverage for physical therapy, chiropractic care, and occupational therapy is provided through the Managed Physical Medicine Program.

Also provides coverage for home care services, durable medical equipment and certain medical supplies through the Home Care Advocacy Program; the Prosthetics/Orthotics Network; Center of Excellence Programs for Cancer and for Infertility; and Benefits Management Program services, including Prospective Procedure Review for MRI, MRA, CT, PET scans, nuclear medicine tests, voluntary specialist consultant evaluation services and outpatient medical case management.

### **Mental Health & Substance Abuse Program**

**administered by Beacon Health Options, Inc.**

Provides coverage for inpatient and outpatient mental health care and substance use care 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.

See *Contact Information* on page 19.

# Benefits Management Program

The 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 Excelsior Plan is your primary coverage (pays first, before another health plan or Medicare).



## YOU MUST CALL

for preadmission certification

**If the Excelsior Plan 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 the Hospital Program (administered by Empire BlueCross BlueShield):

- Before a scheduled (nonemergency) hospital admission, skilled nursing facility admission/transfer or transplant surgery.<sup>†</sup>
- Before a maternity hospital admission.<sup>†</sup> Call as soon as a pregnancy is certain.
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.<sup>†</sup>

If you do not call and the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.

*<sup>†</sup> These services are subject to a \$200 penalty if the hospitalization is determined to be medically necessary, but not precertified.*

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

**If the Excelsior Plan 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 the Medical/Surgical Program (administered by UnitedHealthcare) before receiving the following scheduled (nonemergency) diagnostic tests:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computerized tomography (CT) scan
- 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/Surgical 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 the federal 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, 2018, the out-of-pocket limits for in-network expenses are as follows:

### Individual Coverage

- \$4,800 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- \$2,550 for in-network expenses incurred under the Prescription Drug Program

### Family Coverage

- \$9,600 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- \$5,100 for in-network expenses incurred under the Prescription Drug Program

## Out-of-Network Combined Annual Deductible

The combined annual deductible is \$1,250 for the enrollee, \$1,250 for the enrolled spouse/domestic partner and \$1,250 for all dependent children combined.

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.

## Combined Annual Coinsurance Maximum

The combined annual coinsurance maximum is \$4,000 for the enrollee, \$4,000 for enrolled spouse/domestic partner, and \$4,000 for all dependent children combined.

Coinsurance amounts incurred for Basic Medical Program coverage and non-network Mental Health and Substance Abuse Program coverage count toward the combined annual coinsurance maximum. Copayments to Medical/Surgical Program participating providers and to Mental Health and Substance Abuse Program network providers also count toward the combined annual coinsurance maximum. (**Note:** Copayments made to network facilities do not count toward the combined annual coinsurance maximum.)

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## Preventive Care Services

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

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 a Plan participating provider or network facility. See the *2018 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](http://www.hhs.gov/healthcare/rights/preventive-care).

## Center of Excellence Programs

For further information on any of the programs listed below, refer to the publication *Reporting on Center of Excellence Programs*. In some cases, a travel, lodging and meal allowance may be available. If you do not use a Center of Excellence, benefits are provided in accordance with Hospital and/or Medical/Surgical Program coverage.

### Cancer Services



**YOU MUST CALL** the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program or call the Cancer Resource Services toll free at 1-866-936-6002 and register to participate

Paid-in-full benefits are available for cancer services at a designated Center of Excellence. You will also receive nurse consultations, assistance locating cancer centers and a travel allowance, when applicable.

**Program requirements apply even if Medicare or another health plan is primary to the Excelsior Plan.**

### Transplants Program



**YOU MUST CALL** the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program for prior authorization

Paid-in-full benefits are available for the following transplant services when authorized by the Hospital Program and received at a designated Center of Excellence:

- Pretransplant evaluation of transplant recipient
- Inpatient and outpatient hospital and physician services
- Up to 12 months of follow-up care

You must call the Plan for preauthorization of the following transplants provided through the Center of Excellence for Transplants Program: bone marrow, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell and simultaneous kidney/pancreas.

If you choose to have your transplant in a facility other than a designated Center of Excellence (or if you require a small bowel or multivisceral transplant) you may still take advantage of the Hospital Program case management services, in which a nurse will help you through the transplant process, if you enroll in the Center of Excellence for Transplants Program. If a transplant is authorized but you do not use a designated Center of Excellence, benefits will be provided in accordance with Hospital and/or Medical/Surgical Program coverage. **Note:** Transplant surgery preauthorization is required whether or not you choose to participate in the Center of Excellence for Transplants Program.

**To enroll in the Program and receive these benefits, the Excelsior Plan must be your primary coverage.**

### Infertility Benefits\*



**YOU MUST CALL** the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program for prior authorization

Paid-in-full benefits are available, subject to the lifetime maximum for Qualified Procedures (\$50,000 per covered person) including any applicable travel allowance, when you choose a Center of Excellence for Infertility and receive prior authorization. To request a list of Qualified Procedures, or for preauthorization of infertility benefits, call the Medical/Surgical Program.

### Center of Excellence Program Travel Allowance

When you are enrolled in the Center of Excellence Program or use a Center of Excellence for preauthorized infertility services, a travel, lodging and meal expenses benefit is available for travel within the United States. The benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, the benefit will include coverage for up

*\* Program requirements apply even if Medicare or another health plan is primary to the Excelsior Plan.*

to two companions. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the U.S. General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. Once you arrive at your lodging and need transportation from your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, taxi or bus fare; shuttle; parking; and tolls.

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## Hospital Program



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 pays for covered services provided by a network inpatient or outpatient hospital, skilled nursing facility or hospice setting. There is no coverage for services provided in a non-network facility except in an emergency or if a network facility is not available. The Medical/Surgical Program provides benefits for medical and surgical services, as well as certain hospital services, if 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 statement.

### Network Coverage

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

### Non-network Coverage

Services provided in a hospital, skilled nursing facility or hospice that is not part of The Empire Plan network are not covered.

#### Exceptions

Network coverage applies for services received in a non-network facility when you:

- Receive emergency or urgent services in a non-network facility
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence that can provide the service you require

Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

### Hospital Inpatient



#### **YOU MUST CALL**

for preadmission certification (see page 2)

#### Network Coverage

You pay a \$250 copayment per admission. You will pay a maximum of four inpatient copayments per enrollee, per spouse/domestic partner and per all dependent children combined each calendar year.

You are covered for up to a combined maximum of 365 days per spell of illness for covered inpatient diagnostic and therapeutic services or surgical care in a network hospital.

#### Non-network Coverage

No coverage in a non-network hospital. Exceptions apply based on access, see above.

## Hospital Outpatient

If you are admitted as an inpatient directly from the outpatient department, hospital clinic or emergency department, the hospital outpatient copayment or emergency department copayment is waived and only the hospital inpatient copayment applies.

### Emergency Department

#### Network Coverage

You pay one \$100 copayment per visit to an emergency department, including use of the facility for emergency care, services of the attending physician, services of providers who administer or interpret laboratory tests and electrocardiogram services. Other physician charges are covered under the Medical/Surgical Program (see page 7).

The copayment is waived if you are admitted as an inpatient directly from the emergency department, and only the hospital inpatient copayment applies.

#### Non-network Coverage

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

### Outpatient Department or Hospital Extension Clinic

#### Network Coverage

Outpatient surgery is subject to a \$100 copayment. You pay one \$75 copayment per visit for diagnostic radiology, diagnostic laboratory tests and/or administration of Desferal for Cooley's Anemia.

You have paid-in-full benefits for:

- Preadmission and/or presurgical testing prior to an inpatient admission
- Chemotherapy
- Radiation therapy
- Anesthesiology
- Pathology
- Dialysis

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

*\* Screening, diagnostic and 3-D mammograms are paid in full under New York State law.*

Medically necessary physical therapy following a related hospitalization or related inpatient surgery is subject to a \$30 copayment per visit. Physical therapy must start within six months from your discharge from the hospital or the date of your outpatient surgery and be completed within 365 days from the date of hospital discharge or outpatient surgery.

#### Non-network Coverage

No coverage in a non-network hospital. Exceptions apply in certain situations (see page 5).

## Skilled Nursing Facility Care



### YOU MUST CALL

for preadmission certification (see page 2)

**Benefits are subject to the requirements of the Plan's Benefits Management Program if the Excelsior Plan provides your primary health coverage. The Plan does not provide skilled nursing facility benefits, even for short-term rehabilitative care, for retirees, vestees, dependent survivors or their dependents who are eligible for primary benefits from Medicare.**

#### Network Coverage

Covered in an approved network facility when medically necessary in place of hospitalization.

#### Non-network Coverage

No coverage in a non-network hospital. Exceptions apply in certain situations (see page 5).

## Hospice Care

#### Network Coverage

Care provided by a licensed hospice program is paid in full.

#### Non-network Coverage

No coverage for non-network hospice care. Exceptions apply in certain situations (see page 5).

### 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 Program benefits apply:

#### Participating Provider Program

Covered services are paid in full when the provider participates in The Empire Plan network, except for radiology, anesthesiology or pathology services, which are subject to a \$50 copayment.

#### 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 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 after you pay an initial \$50 copayment, if the Excelsior Plan is your primary coverage. 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 or 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 the Basic Medical Program and are not subject to deductible and coinsurance

All other services subject to deductible and coinsurance.

The Excelsior 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/Surgical Program for more information.

# 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 covers services received from a physician or other practitioner licensed to provide medical/surgical services. The Basic Medical Program also provides coverage for continued hospital inpatient services after hospital inpatient benefits end. Services and supplies must be covered and medically necessary. Call the Medical/Surgical Program if you have questions about coverage, benefits or the status of a provider.

## Participating Provider Program

The Participating Provider Program provides medical/surgical benefits for services/supplies received from a provider that 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 9-11).

The Plan provides guaranteed access for primary care physicians and certain medical specialties.

### Guaranteed Access

When there are no participating providers within a reasonable distance, access to network benefits will be available to enrollees for primary care physicians and certain core provider specialties. To receive this benefit:

- The Excelsior Plan must provide your primary health coverage (pays first, before another health plan or Medicare).
- You must contact the Medical/Surgical Program prior to receiving services and use one of the providers approved by the Program.
- You must contact the provider to arrange care. Appointments are subject to provider's availability, and the Program does not guarantee that a provider will be available in a specified time period.

Reasonable distance from the enrollee's residence is defined by the following mileage standards:

#### **Primary Care**

Urban: 3 miles  
Suburban: 15 miles  
Rural: 40 miles

#### **Specialist**

Urban: 10 miles  
Suburban: 20 miles  
Rural: 40 miles

Network benefits are guaranteed for the following primary care providers and core specialties, within the mileage standards specified above:

#### **Primary Care Providers**

Family practice  
General practice  
Internal medicine  
Pediatrics  
Obstetrics/gynecology

#### **Specialties**

Allergy  
Anesthesia  
Cardiology  
Dermatology  
Laboratory  
Neurology  
Ophthalmology

#### **Specialties Continued**

Orthopedic surgery  
Otolaryngology  
Pathology  
Pulmonary medicine  
Radiology  
Urology

## Basic Medical Program

The Basic Medical Program provides benefits for services/supplies received from a provider that does not participate in The Empire Plan network and also provides coverage for continued hospital inpatient services, after hospital inpatient benefits end. Your out-of-pocket costs are higher when you use a nonparticipating provider.

**Combined annual deductible:** The combined annual deductible must be satisfied before the Plan pays benefits (see page 3).

**Coinsurance:** After you meet the combined annual deductible, the Plan pays 80 percent of the allowed amount.

**Combined annual coinsurance maximum:** After the combined annual coinsurance maximum is reached, benefits are paid at 100 percent of the allowed amount for covered services (see page 3).

### **Allowed Amount**

The allowed amount is:

- 110 percent of the published rates allowed by the Centers for Medicare & Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
- When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology developed by OptumInsight to determine a rate for the service. This methodology uses relative values from the OptumInsight Relative Value Scale, which is usually based on the difficulty, time, work, risk and resources of the service or
- When a rate is not published by CMS and the OptumInsight gap methodology does not apply to the service, the eligible expense is based on 50 percent of the billed charge.

OptumInsight is a wholly-owned subsidiary of UnitedHealthGroup and is an affiliate of UnitedHealthcare. The network allowance generally equates to 13 percent of FAIR Health<sup>®</sup> Usual and Customary professional rates.\* FAIR Health<sup>®</sup> 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](http://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 80<sup>th</sup> percentile of the FAIR Health<sup>®</sup> rates.*

## **Office Visits**

### **Participating Provider Program**

You pay a single \$30 copayment per visit for all covered services provided during the visit and billed by the provider. There is no copayment for prenatal visits, well-child care and preventive services as defined by the Patient Protection and Affordable Care Act.

### **Basic Medical Program**

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

## **Routine Health Exams**

### **Participating Provider Program**

Preventive routine health exams are paid in full. Other covered services received during a routine health exam may be subject to copayment(s).

### **Basic Medical Program**

Routine health exams are covered for active employees age 50 or older, not subject to deductible or coinsurance.

Routine health exams are not covered for dependents (spouse/domestic partner, dependent children), retirees, vestees or dependent survivors.

Covered services, such as laboratory tests and screenings provided during 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.

## Diagnostic Laboratory Services

### Participating Provider Program

You pay a single \$30 copayment for covered services provided by a participating laboratory.

### Basic Medical Program

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

## Diagnostic and Imaging Services

### Participating Provider Program

Imaging procedures subject to Prospective Procedure Review (PPR) are subject to a \$75 copayment:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computerized tomography (CT) scan
- Positron emission tomography (PET) scan
- Nuclear medicine test

You pay a single \$30 copayment for other diagnostic radiology and imaging services received at a participating free-standing (non-hospital based) facility.

**Note:** Interpretation of diagnostic test results billed separately by a different provider are covered separately. You will be subject to copayment or deductible and coinsurance under the Basic Medical Program for that service, depending on the status of the provider.

### Basic Medical Program

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

## Adult Immunizations

### Participating Provider Program

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 (**Note:** This immunization is covered for enrollees age 55 to 59, subject to a \$30 copayment.)

Other immunizations may have a \$30 copayment.

*\* Paid in full 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 18).*

### Basic Medical Program

Not covered.

## Routine Pediatric Care • Up to age 19

### Participating Provider Program

Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and the cost of oral and injectable substances (including the influenza vaccine) when administered according to pediatric immunization guidelines.

### Basic Medical Program

**Routine newborn child care:** Provider services for routine care of a newborn child are covered and not subject to deductible or coinsurance.

**Routine pediatric care:** Routine pediatric care provided by a nonparticipating provider is subject to Basic Medical Program benefits, including deductible and coinsurance.

## Outpatient Surgical Locations

### Participating Provider Program

\$75 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a participating surgical center.

Hospital and hospital-based outpatient surgical locations are covered under the Hospital Program (see *Outpatient Department or Hospital Extension Clinic*, page 6).

### Basic Medical Program

Covered services rendered by a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

## Prostheses and Orthotic Devices

### Participating Provider Program

Prostheses/orthotic devices that meet the individual's functional needs are paid in full.

### Basic Medical Program

Prostheses/orthotic devices that meet the individual's functional needs are subject to Basic Medical Program benefits, including deductible and coinsurance.

## External Mastectomy Prostheses

### Basic Medical Program

One single or double external mastectomy prosthesis is covered under the Basic Medical Program, once per calendar year. This benefit applies whether you use a participating or nonparticipating provider, and is not subject to deductible or coinsurance.

You must call the Medical/Surgical Program and select the Home Care Advocacy Program for precertification of any single prosthesis costing \$1,000 or more. For a prosthesis requiring prior approval, benefits will be available for the most cost-effective prosthesis that meets an individual's functional needs.

## Gender Dysphoria Treatment

### Participating Provider and Basic Medical Programs

Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments when medically necessary. Services related to gender dysphoria treatment that are cosmetic in nature are not covered.

## Emergency Ambulance Service

### Basic Medical Program

Local commercial ambulance charges are covered except the first \$35. When the enrollee has no obligation to pay, donations up to \$50 for trips of fewer than 50 miles and up to \$75 for trips over 50 miles will be reimbursed for voluntary ambulance services. This benefit applies whether you use an ambulance service that is a participating provider or a nonparticipating provider and is not subject to deductible or coinsurance.

## 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 \$30 copayment, which includes related radiology and diagnostic laboratory services billed by the MPN provider.

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.

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

There is no non-network coverage.

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## Home Care Advocacy Program (HCAP)

### Home Care Services, Skilled Nursing Services and Durable Medical Equipment/Supplies



#### YOU MUST CALL

for prior authorization

#### Network Coverage (when you use HCAP)

To receive a paid-in-full benefit, you must call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program, then Benefits Management Program, to precertify and help make arrangements for covered services, durable medical equipment and supplies, including one pair of diabetic shoes per year, insulin pumps, Medi-Jectors and enteral formulas. Diabetic shoes have an annual maximum benefit of \$500. You have guaranteed access to coverage when you follow plan requirements.

**Exceptions:** For diabetic supplies (except insulin pumps and Medi-Jectors), call the Plan's Diabetic Supplies Pharmacy at 1-888-306-7337. For ostomy supplies, call Byram Healthcare Centers at 1-800-354-4054.

**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, Orthotics and Supplies (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](http://www.medicare.gov/supplierdirectory) or contact the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program, then Benefits Management Program/Home Care Advocacy Program.

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

The first 48 hours of nursing care are not covered. After you meet the combined annual deductible (see page 3), the Plan pays up to 50 percent of the HCAP network allowance for covered services, durable medical equipment and supplies. This reimbursement generally equates to 37 percent of FAIR Health<sup>®</sup> Usual and Customary professional rates.\* There is no coinsurance maximum.

\* Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80<sup>th</sup> percentile of the FAIR Health<sup>®</sup> 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 care or substance use care 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 have guaranteed access to network benefits if you contact the Mental Health and Substance Abuse Program before you receive services.

In an emergency, go to the nearest hospital emergency department. You or your designee should call the Mental Health and Substance Abuse Program within 48 hours or as soon as reasonably possible after an emergency mental health care or substance use care hospitalization.

## Network Coverage

You pay only applicable copayments for covered services provided by a provider or facility that is in The Empire Plan network. No deductible or coinsurance applies.

## Non-network Coverage

Your out-of-pocket costs are higher when you use a provider that does not participate in The Empire Plan network, as described in this section.

Services provided in a hospital or inpatient facility that is not part of The Empire Plan network are not covered.

### Exceptions

Network coverage applies for services received in a non-network facility when you:

- Receive emergency or urgent services in a non-network facility
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence
- Use a non-network hospital because you do not have access to a network hospital within 30 miles of your residence that can provide the service you require

Call the Mental Health and Substance Abuse Program to determine if you qualify for network coverage at a non-network hospital based on access.

## Inpatient Services

You should call before an admission to a mental health care or substance use care 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.

### Network Coverage

You pay a \$250 copayment per admission to an approved facility. You will pay a maximum of four inpatient copayments per enrollee, per spouse/ domestic partner and per all dependent children combined each calendar year.

**Practitioner treatment or consultation:** Treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner – not the facility – are paid in full.

### Non-network Coverage

No coverage in a non-network hospital. Exceptions apply in certain situations, see above.

**Practitioner treatment or consultation:** Treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner – not the facility – are subject to deductible and coinsurance as described under *Office Visits and Other Outpatient Services*, page 14.

## Ambulance Service

Ambulance service to a hospital where you receive mental health care or substance use care treatment is covered when medically necessary, except for the first \$35. When the enrollee has no obligation to pay, donations up to \$50 for trips of fewer than 50 miles and up to \$75 for trips over 50 miles will be reimbursed for voluntary ambulance services. This benefit is not subject to deductible or coinsurance.

## Outpatient Services

### Hospital Emergency Department

#### Network Coverage

You pay one \$100 copayment per visit to an emergency department. The copayment is waived if you are admitted as an inpatient directly from the emergency department, and only the inpatient copayment applies.

#### 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 use rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a \$30 copayment per visit.

Up to three visits per crisis are paid in full for mental health care treatment. After the third visit, the \$30 copayment per visit applies.

#### Non-network Coverage

**Combined annual deductible:** The combined annual deductible must be satisfied before the Plan pays benefits (see page 3).

**Coinsurance:** After you meet the combined annual deductible, the Plan pays 80 percent of the allowed amount.

**Combined annual coinsurance maximum:** After the combined annual coinsurance maximum is reached, the Plan pays benefits for covered services at 100 percent of the usual and customary rate (see page 3).

#### Allowed Amount

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

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



### YOU MUST CALL

for prior authorization

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 use diagnosis in a network or non-network setting will be reviewed for medical necessity. As only medically necessary services are covered, 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/Surgical 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.

The Prescription Drug Program provides coverage for prescriptions for covered drugs, up to a 90-day supply, when filled at network, mail service, specialty or non-network pharmacies.

## Copayments

You have the following copayments for covered drugs purchased from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy.

Drug Category	Up to a 30-day Supply from a Network Pharmacy, the Mail Service Pharmacy or the Specialty Pharmacy	31- to 90-day Supply from a Network Pharmacy	31- to 90-day Supply from the Mail Service Pharmacy or the Specialty Pharmacy
Level 1 Drugs	\$10	\$25	\$20
Level 2 Drugs	\$40	\$95	\$95
Level 3 Drugs	\$70	\$180	\$180

## Drugs not Subject to Copayment

Certain covered drugs do not require a copayment:

- 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

## Mandatory Generic Substitution

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the Level 3 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 Excelsior Plan Drug List, 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.

## Excelsior Plan Drug List

The Excelsior Plan Drug List is a managed formulary that may exclude certain drugs in a therapeutic category. The drug list may be subject to change quarterly. For the current drug list, visit our website. Or, call the Prescription Drug Program and request an updated printed copy of the Excelsior Plan Drug List.

### Prior Authorization Required

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

- Acthar HP
- Actimmune
- Actiq
- Adagen
- Adcirca
- Adempas
- Aldurazyme
- Alferon-N
- Ampyra
- Apokyn
- Aralast
- Aranesp
- Arcalyst
- Arestin
- armodafinil
- Aubagio
- Aveed
- Benlysta
- Berinert
- Betaseron
- Bethkis
- Bivigam
- Botox
- Bravelle
- Buphenyl
- Carbaglu
- Cayston
- Cerdelga
- Cerezyme
- Cetrotide
- Cholbam
- chorionic gonadotropin (Novarel, Pregnyl)
- Cinqair
- Cinryze
- Cosentyx
- Cuvitru
- Cystagon
- Cystaran
- Copaxone
- deferoxamine (Desferal)
- Dupixent
- Dysport
- Egrifta
- Elaprase
- Eligard
- Emflaza
- Enbrel
- Epclusa
- Epogen/  
Procrit
- Esbriet
- Exjade
- Exondys-51
- Fabrazyme
- Fentora
- Ferriprox
- Firazyr
- Firmagon
- Flolan
- Forteo
- Fuzeon
- Ganirelix
- Gattex
- Gilenya
- Glassia
- Gonal-F
- Granix
- Growth Hormones
- Haegarda
- Harvoni
- Hetlioz
- Humira
- Hyqvia
- Ilaris
- Immune Globulins
- Increlex
- Infergen
- Inflectra
- Ingrezza
- Intron A
- Jadenu
- Jublia
- Juxtapid
- Kalbitor
- Kalydeco
- Kanuma
- Kerydin
- Kevzara
- Korlym
- Krystexxa
- Kuvan
- Kynamro
- Lamisil
- Lazanda
- Lemtrada
- Letairis
- Leukine
- leuprolide (Lupron)
- Lidoderm
- Lumizyme
- Lupaneta Pack
- Lupron Depot
- Lupron Depot-Ped
- Makena
- Menopur
- Mozobil
- Myalept
- Myobloc
- Myozyme
- Naglazyme
- Natpara
- Neulasta
- Neumega
- Northera
- Nplate
- Nucala
- Nuplazid
- Ocaliva
- Ocrevus
- octreotide (Sandostatin)
- Ofev
- Oncology Drugs
- Onmel
- Onsolis
- Orenitram
- Orfadin
- Orkambi
- Otezla
- Otrexup
- Ovidrel
- Pegasys
- PegIntron
- Prialt
- Procysbi
- Prolastin-C
- Prolia
- Promacta
- Provigil
- Pulmozyme
- Radicava
- Rasuvo
- Ravicti
- Rebif
- Remicade
- Remodulin
- Renflexis
- Repatha
- Repronex
- Revatio
- Ribavirin
- Ruconest
- Sabril
- Samsca
- Sandostatin LAR
- Saxenda
- Sensipar
- Serostim
- Signifor
- Siliq
- Solaraze
- Soliris
- Somatuline Depot
- Somavert
- Sovaldi
- Sporanox
- Stelara
- Strensiq
- Subsys
- Supprelin LA
- Synagis
- Tazorac
- Tecfidera
- tetrabenazine
- Tikosyn
- tobramycin inhalation solution
- Terbinex
- Tracleer
- Trelstar
- Tremfya
- Tymlos
- Tysabri
- Tyvaso
- Uptravi
- Vantus
- Veletri
- Ventavis
- Victrelis
- Vimizim
- Vivitrol
- Vosevi
- VPRIV
- Weight Loss Drugs
- Xeomin
- Xolair

- Xyrem
- Zavesca
- Zinbryta
- zoledronic acid (Reclast)
- Zarxio
- Zemaira
- Zoladex

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 U.S. Food and Drug Administration (FDA), 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 website, and select Using Your Benefits and then Drugs that Require Prior Authorization.

### Excluded Drugs

Certain brand-name and generic drugs are excluded from the Excelsior Plan Drug List if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2018 Excelsior Plan Drug List includes drugs that are excluded in 2018, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. Check the website for current information regarding exclusions of newly launched prescription drugs.

### Newly Excluded Drugs for 2018

- Actemra
- Benicar/Benicar HCT
- Cimzia
- Doryx/ Doryx MPC
- Dulera
- Effexor XR
- Elelyso
- Entyvio
- Follistim AQ
- Horizant
- Hyalgan
- Jardiance
- Kineret
- Mavyret
- Monodox
- Nuvigil
- Orenzia
- Clickject/Orenzia Subcutaneous
- Primlev
- Seroquel XR
- Simponi
- Sprix
- Stendra
- Sumavel Dosepro
- Synjardy/ Synjardy XR
- Synvisc/ Synvisc One
- Taltz
- Tanzeum
- Xeljanz/Xeljanz XR
- Zetia

### Medical Exception Program for Excluded Drugs

A medical exception program 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 Excelsior Plan Drug List 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 website 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](http://www.empireplanrxprogram.com) and select CVS Caremark, then Find a Local Pharmacy. 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. (Note: This immunization is covered for enrollees age 55 through 59, subject to a \$10 copayment.)*

## Mail Service Pharmacy

You may fill your prescription by mail through the CVS Caremark Mail Service Pharmacy using a 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 or online at [www.empireplanrxprogram.com](http://www.empireplanrxprogram.com) or download forms at [www.cs.ny.gov](http://www.cs.ny.gov). From the NYSHIP Online homepage, click on Forms and scroll down to the CVS Caremark Mail Service Order Form.

## Specialty Pharmacy Program

The 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 the 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) Monday through Friday between 7:30 a.m. and 9 p.m. 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](http://www.cs.ny.gov). From the NYSHIP Online homepage, 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 Excelsior Plan 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 Excelsior Plan Drug List.

## Contact Information

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

<b>PRESS OR SAY 1</b>	<p><b>Medical/Surgical Program: Administered by UnitedHealthcare</b>                  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: <a href="https://nyrmo.optummessenger.com/public/opensubmit">https://nyrmo.optummessenger.com/public/opensubmit</a></p>
<b>PRESS OR SAY 2</b>	<p><b>Hospital Program: Administered by Empire BlueCross BlueShield</b>                  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: <a href="http://www.empireblue.com">www.empireblue.com</a></p>
<b>PRESS OR SAY 3</b>	<p><b>Mental Health and Substance Abuse Program: Administered by Beacon Health Options, Inc.</b>                  Representatives are available 24 hours a day, seven days a week.                  TTY: 1-855-643-1476 P.O. Box 1850, Hicksville, NY 11802                  Claims submission fax: 855-378-8309 Online: <a href="https://ets.valueoptions.com/OnlineClaimSubmission">https://ets.valueoptions.com/OnlineClaimSubmission</a></p>
<b>PRESS OR SAY 4</b>	<p><b>Prescription Drug Program: Administered by CVS Caremark</b>                  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</p>
<b>PRESS OR SAY 5</b>	<p><b>Empire Plan NurseLine<sup>SM</sup>: Administered by UnitedHealthcare</b>                  Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.</p>

### 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 program administrator website, 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](http://www.cs.ny.gov). Select State Employees, then Health Benefits. Choose your group and plan, if prompted, and you can then bookmark this page to bypass the login screen the next time you visit the website.

This document provides a brief look at the Excelsior Plan benefits for enrollees of Participating Agencies. 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, Albany, New York 12239

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

The *Excelsior Plan At A Glance* is published by the Employee Benefits Division of the New York State Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits through the Excelsior Plan.



**Please do not send mail or correspondence to the return address above. See boxed address page 19.**

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. 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 agency Health Benefits Administrator (HBA). COBRA Enrollees: Contact your former HBA.

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### The Excelsior Plan Copayments at a Glance

The listed copayments apply when services are received under the Participating Provider Program or network coverage. 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.

<p><b>Medical/Surgical Program</b></p>	<p>\$30 copayment – Office visit, office surgery, diagnostic laboratory tests, freestanding cardiac rehabilitation center visit, urgent care center visit, convenience care clinic visit</p> <p>\$75 copayment – Non-hospital outpatient surgical locations</p> <p>\$75 copayment – Prospective Procedure Review for MRIs, MRAs, CT scans, PET scans and nuclear medicine tests</p> <p><b>Chiropractic treatment or physical therapy services (Managed Physical Medicine Program)</b></p> <p>\$30 copayment – Office Visit, Radiology, Diagnostic Laboratory Tests</p>
<p><b>Hospital Program</b></p>	<p>\$30 copayment – Outpatient physical therapy</p> <p>\$75 copayment – Diagnostic radiology, diagnostic laboratory tests, administration of Desferal for Cooley’s Anemia in a network hospital or hospital extension clinic</p> <p>\$100 copayment – Emergency department visit, outpatient surgery</p> <p>\$250 copayment – Inpatient hospital stay</p>
<p><b>Mental Health and Substance Abuse Program</b></p>	<p>\$30 copayment – Visit to an outpatient substance use treatment program</p> <p>\$30 copayment – Visit to a mental health professional</p> <p>\$100 copayment – Emergency department visit</p> <p>\$250 copayment – Inpatient hospital stay</p>
<p><b>Prescription Drug Program</b></p>	<p>Up to a 90-day supply from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy (see copayment chart on page 15).</p>