OCTOBER 2016

Health Insurance Choices for 2017

For employees of the State of New York, Participating Employers, their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees

NEW YORK STATE

NYSHIP
New York State
Health Insurance Program

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Information & Reminders

Make Your Health Plan Choices

This booklet explains the options available to you under the New York State Health Insurance Program (NYSHIP) for your health insurance and other elections. You may choose coverage under The Empire Plan or one of the NYSHIP-approved health maintenance organizations (HMOs) in your area. Or, if you can be covered under other employer-sponsored group health benefits, you may be eligible to elect the Opt-out Program.*

Consider your options carefully. You may not change your option after the deadline, except in special circumstances (see your *NYSHIP General Information Book* and *Empire Plan Reports* or *HMO Reports* for details about changing options outside the Option Transfer Period). If you still have questions after you have read the information in this booklet, contact your Health Benefits Administrator (HBA) or The Empire Plan program administrators and HMOs directly.

Rates for 2017 and Deadline for Changing Plans

The Empire Plan and HMO rates for 2017 will be mailed to your home and posted on our web site, NYSHIP Online, as soon as they are approved. To find this information online, go to www.cs.ny.gov/employee-benefits. Next, select your group and plan, if prompted, and then Health Benefits & Option Transfer. Choose Rates and Health Plan Choices.

Note: Participating Employers (PEs), such as the Thruway Authority and the Metropolitan Transportation Authority, will notify their enrollees of 2017 rates.

The rate flyer announces the option-change deadline and dates that changes in health insurance payroll deductions will occur. You will have 30 days from the date your agency receives rate information to make a decision. Your HBA can help if you have questions. COBRA and Young Adult Option enrollees may contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (United States, Canada, Puerto Rico and the Virgin Islands).

* The Opt-out Program is available to eligible NYS employees who have other employer-sponsored group health insurance. Check with your HBA if you have any questions about your eligibility for the Opt-out Program. Employees of Participating Employers in NYSHIP should check with their HBA to determine if their employer offers a program similar to the Opt-out Program. See page 15 for more information about this program.

Changing Your 2017 Pre-Tax Contribution Program (PTCP) Status (November 30, 2016 Deadline)

PTCP does not apply to COBRA and Young Adult Option enrollees or retirees. The following also may not apply to Participating Employers. PEs that participate in a pre-tax contribution program will provide specific pre-tax information to their employees.

Under PTCP, your share of the health insurance premium is deducted from your wages before taxes are withheld, which may lower your tax liability.

NO ACTION IS REQUIRED TO KEEP YOUR CURRENT PTCP STATUS.

If you wish to change your PTCP selection for 2017, submit a signed and completed *Health Insurance Transaction Form* (PS-404) to your HBA between November 1 and November 30, 2016.

Checking Your PTCP Status

Your paycheck shows whether or not you are enrolled in PTCP.

- If you are enrolled in PTCP or part of your deduction is being taken after tax (e.g., for a non-federally qualifying dependent), your paycheck stub shows "Regular Before-Tax Health" in the Before-Tax Deductions section. Your health insurance premium is deducted from your wages before taxes are withheld.
- If you are not enrolled in PTCP, your paycheck stub shows "Regular After-Tax Health" in the After-Tax Deductions section. Your health insurance premium is deducted from your wages after taxes are withheld.

NEW ENROLLEES

When enrolling in NYSHIP coverage, new enrollees must elect whether or not to participate in PTCP. No election will be made automatically on the enrollee's behalf. Enrollment cannot be completed without a PTCP election.

PTCP ENROLLMENT LIMITS MID-YEAR CHANGES

Under Internal Revenue Service (IRS) rules, if you are enrolled in PTCP, you may not change your **pre-tax payroll deduction for health benefits** during the Plan year (by changing your health benefit option, changing your coverage [Family or Individual] or by canceling coverage) unless a PTCP-qualifying event occurs. Requests to change your pre-tax deduction during the tax year must be consistent (for all individuals covered under the contract) with qualifying life events and must be requested within 30 days of the event. You may not change your pre-tax payroll deduction for health benefits (other than during the PTCP Enrollment Period or Option Transfer Period), except when one of the following PTCP-qualifying events occurs:

- change in marital status
- change in number of dependents
- change in your (or your dependent's) employment status that affects eligibility for health benefits
- your dependent satisfies or ceases to satisfy eligibility requirements for health benefits
- change in your (or your dependent's) place of residence or worksite that affects eligibility for benefits
- significant change in health benefits and/or premium under NYSHIP
- significant change in health benefits and/or premium under your (or your dependent's) other employer's plan
- COBRA events
- judgment, decree or order to provide health benefits to eligible dependents
- Medicare or Medicaid eligibility
- leaves of absence
- HIPAA special enrollment rights

A coverage change due to a qualifying event must be requested within 30 days of the event (or within the waiting period if newly eligible); delays may be costly.

See your HBA to change your health insurance option, type of coverage or pre-tax status.

NO ACTION IS REQUIRED IF YOU DO NOT WISH TO MAKE CHANGES (unless you wish to continue enrollment in the **Opt-out Program**; see page 15). Changes are not automatic, and deadlines apply. You must report any change that may affect your coverage to your HBA. See pages 1-3 in this booklet and your *NYSHIP General Information Book* for complete information.

Information & Reminders

Your Share of the Premium

The following does not apply to employees of Participating Employers. PEs will provide premium information. It also does not apply to COBRA enrollees, Young Adult Option enrollees or enrollees in Leave Without Pay status (who pay the full cost of coverage).

New York State helps pay for your health insurance coverage. After the State's contribution, you are responsible for paying the balance of your premium, usually through biweekly deductions from your paycheck.

Whether you enroll in The Empire Plan or in a NYSHIP HMO, the State's share and your share of the cost of coverage are based on the following (salary requirements vary; contact your HBA for more information):

Enrollee Pay Grade	Individual Coverage		Dependent Coverage	
	State Share	Employee Share	State Share	Employee Share
Grade 9 and below*	88%	12%	73%	27%
Grade 10 and above*	84%	16%	69%	31%

* Or salary equivalent, if no Grade assigned. Contact your HBA to confirm.

If you enroll in a NYSHIP HMO, the State's dollar contribution for the hospital, medical/surgical and mental health and substance abuse components of your HMO premium will not exceed its dollar contribution for those components of The Empire Plan premium. For the prescription drug component of your HMO premium, the State pays the share noted in the table; the dollar amount is not limited by the cost of Empire Plan drug coverage.

As soon as they are approved, 2017 rates will be mailed to your home and posted on NYSHIP Online at www.cs.ny.gov/employee-benefits. Select your group and plan, if prompted, and then Health Benefits & Option Transfer. Choose Rates and Health Plan Choices.

Let Your Agency Know about Changes

You must notify your HBA if your home address or phone number changes. If you are an active employee of New York State and registered for MyNYSHIP, you may also make address and option changes online. **Note:** MyNYSHIP is not available for active employees of PEs.

Changes in your family status, such as gaining or losing a dependent, may mean you need to change your health insurance coverage from Individual to Family or from Family to Individual. If you submit a timely request after a change in family status, you may make changes outside the Option Transfer Period without experiencing a waiting period. See your *NYSHIP General Information Book* for details. Promptly inform your HBA about any change to ensure it is effective on the actual date of change in family status.

If You Retire or Leave State Service in 2017

If you continue your NYSHIP enrollment as a retiree or vestee, you may change your health insurance plan when your status changes. As a retiree or vestee, you may change health insurance options at any time once during a 12-month period. For more information on changing options as a retiree or vestee, ask your HBA for *2017 Choices* for Retirees.

If You Become Eligible for Medicare in 2017

If you or a dependent is eligible for Medicare because of age or disability, see Medicare and NYSHIP on page 6 for important information. Please read this Medicare section if you or any dependent will be turning 65 in 2017 or if you are planning to retire in the coming year and will become Medicare primary.

Comparing Your NYSHIP Options

Choosing the option that best meets your needs and the needs of your family requires careful consideration. As with most important purchases, there is more to consider than cost.

The first step toward making a good choice is understanding the similarities and differences among your NYSHIP options. There are two types of health insurance plans available to you under NYSHIP: The Empire Plan and NYSHIP HMOs. The Empire Plan is available to all employees. NYSHIP HMOs are available in various geographic areas of New York State. Depending on where you live or work, one or several NYSHIP HMOs will be available to you. The Empire Plan and NYSHIP HMOs are similar in many ways but also have important differences.

Additionally, if you have other employer-sponsored group health benefits available to you, you may be eligible for the Opt-out Program (see page 15 for details).

Benefits

THE EMPIRE PLAN AND NYSHIP HMOS

- All NYSHIP plans provide a wide range of hospital, medical/surgical and mental health and substance abuse coverage.
- All plans provide prescription drug coverage for those who do not receive it through a union Employee Benefit Fund.
- All plans provide coverage for certain preventive care services as required by the federal Patient Protection and Affordable Care Act (PPACA). For more information on preventive care services, visit www.hhs.gov/healthcare/rights/preventive-care or NYSHIP Online.

Benefits differ among plans. Read this booklet and the Empire Plan Certificate *(available from your HBA) and HMO contracts (available from each HMO) for details.*

Exclusions

- All plans contain coverage exclusions for certain services and prescription drugs.
- Workers' compensation-related expenses and custodial care generally are excluded from coverage.

For details on a plan's exclusions, read the *Empire Plan Certificate* or the NYSHIP HMO contract or check with the plan directly.

Geographic Area Served

THE EMPIRE PLAN

Benefits for covered services, not just urgent and emergency care, are available worldwide. However, access to **network benefits** is not guaranteed in all states and regions.

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

- Coverage is available in each HMO's specific service area.
- An HMO may arrange for coverage of care received outside its service area at its discretion in certain circumstances. See the out-of-area benefit description on each HMO page for more detailed information.

Terms to Know

Coinsurance: The enrollee's share of the cost of covered services, which is a fixed percentage of covered medical expenses.

Copayment: The enrollee's share of the cost of covered services, which is a fixed dollar amount paid when a medical service is received, regardless of the total charge for the service.

Deductible: The dollar amount an enrollee is required to pay before health plan benefits begin to reimburse for services.

Fee-for-service: A method of billing for health care services. A provider charges a fee each time an enrollee receives a service.

Formulary: A list of preferred drugs used by a health plan. A plan with a **closed formulary** provides coverage only for drugs that appear on the list. An **open or incented formulary** encourages use of preferred drugs to non-preferred drugs based on a tiered copayment schedule. In a **flexible formulary**, brand-name prescription drugs may be assigned to different copayment levels based on value to the plan and clinical judgment. In some cases, drugs may be excluded from coverage under a flexible formulary if a therapeutic equivalent is covered or available as an over-the-counter drug.

Health Benefits Administrator (HBA): An individual responsible for providing benefits assistance to active State employees. HBAs work with the Employee Benefits Division in the Department of Civil Service to process transactions and answer questions regarding eligibility and enrollment. You are responsible for notifying your HBA of changes that affect your enrollment and/or your or your dependents' eligibility for benefits.

Health Maintenance Organization (HMO): A managed care delivery system organized to deliver health care services in a geographic area. An HMO provides a predetermined set of benefits through a network of selected physicians, laboratories and hospitals for a prepaid premium. Except for emergency services and other services approved by your HMO, you and your enrolled dependents may have coverage only for services received from your HMO's network. See NYSHIP Health Maintenance Organizations on pages 9 and 10 for more information on HMOs.

Managed Care: A health care program designed to ensure you receive the highest quality medical care for the lowest cost in the most appropriate health care setting. Most managed care plans require you to select a primary care physician employed by (or who contracts with) the managed health care system. He or she serves as your health care manager by coordinating virtually all health care services you receive. Your primary care physician provides your routine medical care and refers you to a specialist if necessary.

Medicare: A federal health insurance program that covers certain people age 65 or older, disabled persons under 65 and those who have end-stage renal disease (permanent kidney failure). Medicare is directed by the federal Centers for Medicare & Medicaid Services (CMS), and enrollment in Medicare is administered by the Social Security Administration.

Medicare Advantage Plan: A Medicare option wherein the plan agrees with Medicare to accept a fixed monthly payment for each Medicare enrollee. In exchange, the plan provides or pays for all medical care needed by the enrollee. If you join a Medicare Advantage Plan, you replace your original (fee-for-service) Medicare coverage (Parts A and B) with benefits offered by the plan and all of your medical care (except for emergency or out-of-area, urgently needed care) must be provided, arranged or authorized by the Medicare Advantage Plan. All NYSHIP Medicare Advantage HMOs include Medicare Part D drug coverage. The benefits under these plans are set in accordance with federal guidelines for Medicare Advantage Plans.

Network: A group of doctors, hospitals and/or other health care providers who participate in a health plan and agree to follow the plan's procedures.

New York State Health Insurance Program (NYSHIP): NYSHIP covers more than 1.2 million public employees, retirees and dependents. It is one of the largest group health insurance programs in the country. The Program provides health care benefits through The Empire Plan and NYSHIP-approved HMOs.

Option: A health insurance plan offered through NYSHIP. Options include The Empire Plan and NYSHIP-approved HMOs within specific geographic areas. The Opt-out Program (NYSHIP code #700) is also considered a NYSHIP option.

Primary/Medicare primary: A health insurance plan is primary when it is responsible for paying health benefits claims before any other group health insurance plan. It is important to understand when Medicare will become primary to your NYSHIP coverage. Read plan documents for complete information.

NYSHIP'S YOUNG ADULT OPTION

During the Option Transfer Period, eligible adult children of NYSHIP enrollees can enroll in the Young Adult Option and current Young Adult Option enrollees are able to switch plans. This option allows unmarried, young adult children up to age 30 to purchase their own NYSHIP coverage. The premium is the full cost of Individual coverage for the option selected.

Young Adult Option Web Site

For more information about the Young Adult Option, go to www.cs.ny.gov/yao and choose your group. This site is your best resource for information on NYSHIP's Young Adult Option. If you have additional questions, please contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344.

Medicare & NYSHIP

If you are an active employee, NYSHIP (The Empire Plan or a NYSHIP HMO) provides primary coverage for you and your dependents, regardless of age or disability. **Exceptions:** Medicare is primary for domestic partners age 65 or older or for an active employee or dependent of an active employee with end-stage renal disease (following a 30-month coordination period).

NYSHIP requires you and your dependents to be enrolled in Medicare Parts A and B when first eligible for Medicare coverage that pays primary to NYSHIP.

If you are planning to retire and you or your spouse is 65 or older, contact your Social Security office three months before active employment ends to enroll in Medicare Parts A and B. Medicare becomes primary to your NYSHIP coverage the first day of the month following a "runout" period of 28 days after the end of the payroll period in which you retire.*

If you or a dependent is eligible for Medicare coverage primary to NYSHIP and you don't enroll in Parts A and B, The Empire Plan or HMO will not provide benefits for services Medicare would have paid if you or your dependent had enrolled.**

If you are planning to retire or vest in 2017, learn how primary Medicare coverage will affect NYSHIP:

- **If you are enrolled in original Medicare (Parts A and B) and The Empire Plan:** Because Medicare does not provide coverage outside the United States, The Empire Plan pays primary for covered services received outside the United States.
- **If you enroll in a NYSHIP HMO Medicare Advantage Plan:** You replace your original Medicare coverage with benefits offered by the Medicare Advantage Plan. Benefits and networks under the HMO's Medicare Advantage Plan may differ from your coverage as an active employee. To qualify for benefits, you must follow plan rules.
- **If you enroll in a NYSHIP HMO that coordinates coverage with Medicare:** You receive the same benefits from the HMO as an active employee and still qualify for original Medicare benefits if you receive services not covered through your HMO.

Medicare Part D is the prescription drug benefit for Medicare-primary persons. Medicare-primary Empire Plan enrollees and dependents are enrolled automatically in Empire Plan Medicare Rx, a Part D prescription drug program. NYSHIP Medicare Advantage HMOs also provide Medicare Part D prescription drug coverage. You can be enrolled in only one Medicare product at a time. **Enrolling in a Medicare Part D plan or Medicare Advantage Plan separate from your NYSHIP coverage may drastically reduce your benefits overall.** For example:

- If you are a Medicare-primary Empire Plan enrollee or dependent and get your prescription drug coverage through Empire Plan Medicare Rx and then you enroll in another Medicare Part D plan outside of NYSHIP, the Centers for Medicare & Medicaid Services (CMS) will terminate your coverage in Empire Plan Medicare Rx. Because you must be enrolled in Empire Plan Medicare Rx to maintain Empire Plan coverage, in most cases, you and your covered dependents will lose all coverage under The Empire Plan.
- If you are enrolled in a NYSHIP Medicare Advantage HMO and then enroll in a Medicare Part D plan outside of NYSHIP, CMS will terminate your enrollment in the HMO.

If you have been approved for Extra Help by Medicare and you are enrolled in The Empire Plan or a NYSHIP Medicare Advantage HMO, you may be reimbursed for some or all of your cost for Medicare Part D coverage. For information about qualifying for Extra Help, contact Medicare. If you have been approved for Extra Help, contact the Employee Benefits Division or your HMO.

If you receive prescription drug coverage through a union Employee Benefit Fund, contact the fund for information about Medicare Part D.

For more information about NYSHIP and Medicare, see your *NYSHIP General Information Book* or ask your HBA for a copy of *2017 Choices* for Retirees, *Planning for Retirement* or *Medicare & NYSHIP.*

* If you are an employee of a PE, you may have a different "runout" period. Verify with your HBA.

** If you are asked to pay a Part A premium, see your HBA for more information.

Benefits Provided by All Plans

- inpatient medical/surgical hospital care
- outpatient medical/surgical hospital services
- physician services
- emergency services*
- laboratory services
- radiology services
- chemotherapy
- radiation therapy
- dialysis
- diagnostic services
- diabetic supplies
- maternity, prenatal care
- well-child care
- chiropractic services
- skilled nursing facility services
- physical therapy
- occupational therapy
- speech therapy
- prosthetics and durable medical equipment
- orthotic devices
- medically necessary bone density tests
- mammography
- inpatient mental health services
- outpatient mental health services
- alcohol and substance abuse detoxification
- inpatient alcohol rehabilitation
- inpatient drug rehabilitation
- outpatient alcohol and drug rehabilitation
- family planning and certain infertility services (call The Empire Plan program administrators or NYSHIP HMOs for details)
- out-of-area emergencies
- hospice benefits (at least 210 days)
- home health care in lieu of hospitalization
- prescription drug coverage including injectable and self-injectable medications, contraceptive drugs and devices and fertility drugs (unless you have coverage through a union Employee Benefit Fund)
- enteral formulas covered through either HCAP for The Empire Plan or the NYSHIP HMO's prescription drug program (unless you have coverage through a union Employee Benefit Fund)
- second opinion for cancer diagnosis

Please see the individual plan descriptions in this booklet to review the differences in coverage and out-of-pocket expenses. See plan documents for complete information on benefits.

* Some plans may exclude coverage for airborne ambulance services. Call The Empire Plan or your NYSHIP HMO for details.

The Empire Plan or a NYSHIP HMO

What's New?

THE EMPIRE PLAN

- For 2017, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan will be $7,150 for Individual coverage and $14,300 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. **See table below for more information about how out-of-pocket limits apply to each Empire Plan program.**

The Empire Plan

The Empire Plan is a unique plan designed exclusively for New York State's public employees. The Empire Plan has many managed care features, but enrollees are not required to choose a primary care physician and do not need referrals to see specialists. However, certain services, such as hospital and skilled nursing facility admissions, certain outpatient radiological tests, certain mental health and substance abuse treatment/services, home care and some prescription drugs, require preapproval.

The New York State Department of Civil Service contracts with qualified companies to administer the Plan. The Empire Plan is self insured.

The Empire Plan provides:

- Network and non-network inpatient and outpatient hospital coverage for medical, surgical and maternity care.
- Medical and surgical coverage under the Participating Provider Program or the Basic Medical Program and Basic Medical Provider Discount Program if you choose a nonparticipating provider.
- Home care services, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes through the Home Care Advocacy Program (HCAP).
- Chiropractic treatment and physical therapy coverage through the Managed Physical Medicine Program.
- Inpatient and outpatient mental health and substance abuse coverage.
- Prescription drug coverage, unless it is provided by a union Employee Benefit Fund.
- Center of Excellence Programs for cancer, transplants and infertility.
- 24-hour Empire Plan NurseLine℠ for health information and support.
- Worldwide coverage.

2017 Empire Plan Maximum Out-of-Pocket Limits for In-Network Services

Coverage Type	Prescription Drug Program*	Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs, Combined	Total
Individual Coverage	$2,500	$4,650	$7,150
Family Coverage	$5,000	$9,300	$14,300

* Does not apply to Medicare-primary enrollees or the dependents of Medicare-primary enrollees.

PROVIDERS

Under The Empire Plan, you can choose from more than 250,000 participating physicians and other providers and facilities nationwide and from more than 68,000 participating pharmacies across the United States or a mail service pharmacy.

Some licensed nurse practitioners and convenience care clinics participate with The Empire Plan. Be sure to confirm participation before receiving care.

Under the Guaranteed Access benefit, The Empire Plan provides access to network benefits for covered services provided by primary care physicians and certain specialists when you do not have access to a network provider in New York State and specific counties in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont that share a border with New York State. **Note:** This benefit does not apply to enrollees of PEs.

NYSHIP Health Maintenance Organizations

A health maintenance organization (HMO) is a managed care system in a specific geographic area that provides comprehensive health care coverage through a network of providers.

- Coverage for services received outside the specified geographic area is limited. HMO enrollees who use doctors, hospitals or pharmacies outside the HMO's network must, in most cases, pay the full cost for services unless authorized by the HMO or in the case of an emergency.
- Enrollees usually choose a primary care physician (PCP) from the HMO's network for routine medical care and for referrals to specialists and hospitals when medically necessary.
- HMO enrollees usually pay a copayment as a per-visit fee or coinsurance (percentage of cost).
- HMOs have no annual deductible.
- Referrals to network specialists may be required.
- Claim forms rarely are required.

All NYSHIP HMOs provide a wide range of health services. Each offers a specific package of hospital, medical, surgical and preventive care benefits. These services are provided or arranged by the PCP selected by the enrollee from the HMO's network.

CONSIDER COST

When considering cost, think about all your costs throughout the year, not just your biweekly paycheck deduction. Keep in mind any out-of-pocket expenses you are likely to incur during the year, such as copayments for prescriptions and other services, coinsurance and any costs of using providers or services not covered under the plan. Watch for the *NYSHIP Rates & Deadlines for 2017* flyer that will be mailed to your home and posted on our web site, www.cs.ny.gov/employee-benefits, as soon as rates are approved. (**Note:** PEs will provide premium information to their employees). Along with this booklet, which provides copayment information, *NYSHIP Rates & Deadlines for 2017* will provide the information you need to determine your annual cost under each of the available plans.

The Empire Plan or a NYSHIP HMO

All NYSHIP HMOs cover inpatient and outpatient hospital care at a network hospital and prescription drug coverage.*

NYSHIP HMOs are organized in one of two ways:

- A network HMO provides medical services through its own health centers, as well as outside participating physicians, medical groups and multispecialty medical centers.
- An independent practice association (IPA) HMO provides medical services through private practice physicians who have contracted independently with the HMO to provide services in their offices.

A member enrolling in a network or IPA model HMO may be able to select a doctor he or she already uses if that doctor participates with the HMO.

See the individual HMO pages in this booklet for additional benefit information and to learn which HMOs serve your geographic area.

NYSHIP HMOS AND MEDICARE

If you are Medicare primary, see page 6 for an explanation of how Medicare affects your NYSHIP HMO coverage.

Summary of Benefits and Coverage

The *Summary of Benefits and Coverage* (*SBC*) is a standardized comparison document required by the Patient Protection and Affordable Care Act (PPACA).

To view a copy of an *SBC* for The Empire Plan or a NYSHIP HMO, visit www.cs.ny.gov/sbc/index.cfm. If you do not have internet access, call 1-877-7-NYSHIP (1-877-769-7447) and select the Medical Program to request a copy of the *SBC* for The Empire Plan. If you need an *SBC* for a NYSHIP HMO, contact the HMO.

* For PE employees: Unless prescription drug coverage is provided through a union Employee Benefit Fund.

Making a Choice

Selecting a health insurance plan is an important and personal decision. Only you know your family's lifestyle, health, budget and benefit preferences. Think about what health care you and your covered dependents might need during the next year. Review the plans, and ask for more information. Here are several questions to consider:

- What is my premium for the health plan?
- What benefits does the plan have for office visits and other medical care? What is my share of the cost?
- What benefits does the plan have for prescription drugs? Will the medicine I take be covered under the plan? What is my share of the cost? What type of formulary does the plan have? Am I required to use the mail service pharmacy? (If you receive your drug coverage from a union Employee Benefit Fund, ask the fund about your benefits.)
- Does the plan cover special needs? How is durable medical equipment and other supplies covered? Are there any benefit limitations? (If you or one of your dependents has a medical or mental health/substance abuse condition requiring specific treatment or other special needs, check on coverage carefully. Do not assume you will have coverage. Ask The Empire Plan program administrators or HMOs about your specific treatment.)
- Are routine office visits and urgent care covered for out-of-area college students, or is only emergency health care covered?
- What benefits are available for a catastrophic illness or injury?
- What choice of providers do I have under the plan? (Ask if the provider or facilities you use are covered.) How would I consult a specialist if I needed one? Would I need a referral?
- How much paperwork is involved in the health plan? Do I have to fill out forms?

Things to Remember

- Gather as much information as possible.
- Consider your and your family's unique needs.
- Compare the coverage and cost of your options.
- Look for a health plan that provides the best balance of cost and benefits for you.

How to Use the Choices Benefit Charts, Pages 18 – 43

The Empire Plan and NYSHIP HMOs are summarized in this booklet. The Empire Plan is available to all employees. You may choose an available NYSHIP HMO based on the area in which you live or work. Identify the plans that best serve your needs, and call each plan for details before you choose.

All NYSHIP plans must include a minimum level of benefits (see page 7). For example, The Empire Plan and all NYSHIP HMOs provide a paid-in-full benefit for medically necessary inpatient hospital care at network hospitals.

Use the charts to compare plans. The charts list out-of-pocket expenses and benefit limitations effective January 1, 2017. See plan documents for complete information on benefit limitations.

To generate a side-by-side comparison of the benefits provided by each of the NYSHIP plans in your area, use the NYSHIP Plan Comparison tool, available on NYSHIP Online. Go to our homepage at www.cs.ny.gov/employee-benefits. Select your group and plan, if prompted, and then choose Health Benefits & Option Transfer. Click on Rates and Health Plan Choices and then NYSHIP Plan Comparison. Select your group and the counties in which you live and work. Then, check the box next to the plans you want to compare and click on Compare Plans to generate the comparison table.

Note: Most benefits described in this booklet are subject to medical necessity and may involve limitations or exclusions. Please refer to plan documents or call the plans directly for details.

If You Decide to Change Your Plan

If you have reviewed the coverage and cost of your options and decide to change your plan, submit a completed *Health Insurance Transaction Form* (PS-404) or change your option online using MyNYSHIP (if you are an active employee of a New York State agency) before the Option Transfer deadline announced in the rate flyer. **Note:** MyNYSHIP cannot be used to elect the Opt-out Program (see page 15).

Will I be covered for medically necessary care I receive away from home?

The Empire Plan:

Yes. The Empire Plan provides worldwide coverage. However, access to **network benefits** is not guaranteed in all states and regions.

NYSHIP HMOs:

Under an HMO, you are always covered for emergency care. Some HMOs may provide coverage for routine care outside the HMO service area. Some HMOs provide coverage for college students away from home if the care is urgent or if follow-up care has been preauthorized. See the out-of-area benefit description on each HMO page for more information, or contact the HMO directly.

If I am diagnosed with a serious illness, can I see a physician or go to a hospital that specializes in my illness?

The Empire Plan:

Yes. You can use the specialist of your choice. If the doctor you choose participates in The Empire Plan network, benefits will apply for covered services. You have Basic Medical Program benefits for nonparticipating providers and Basic Medical Provider Discount Program benefits for nonparticipating providers who are part of the Empire Plan MultiPlan group (see page 21 for more information on the Basic Medical Provider Discount Program). Your hospital benefits will differ depending on whether you choose a network or non-network hospital (see page 13 for details).

NYSHIP HMOs:

You should expect to choose a participating physician and a participating hospital. Under certain circumstances, you may be able to receive a referral to a specialist care center outside the network.

Can I be sure I will not need to pay more than my copayment when I receive medical services?

The Empire Plan:

Your copayment should be your only expense if you receive medically necessary and covered services and you use a participating provider.

NYSHIP HMOs:

As long as you receive medically necessary and covered services, follow HMO requirements and receive the appropriate referral (if required), your copayment or coinsurance should be your only expense.

HMOs: Similarities and Differences

Can I use the hospital of my choice?

The Empire Plan:

Yes. You have coverage worldwide, but your benefits differ depending on whether you choose a network or non-network hospital. Your benefits are highest at network hospitals participating in the BlueCross and BlueShield Association BlueCard® PPO Program or for mental health or substance abuse care in the Beacon Health Options network.

Network hospital inpatient: Paid-in-full hospitalization benefits.

Network hospital outpatient and emergency care: Subject to network copayments.

Non-network hospital inpatient stays and outpatient services: 10 percent coinsurance for inpatient stays and the greater of 10 percent coinsurance or $75 for outpatient services, up to the combined annual coinsurance maximum per enrollee, per enrolled spouse or domestic partner and per all enrolled dependent children combined (see page 20).

NYSHIP HMOs:

Except in an emergency, you generally do not have coverage at non-network hospitals unless authorized by the HMO.

What kind of care is available for physical therapy and chiropractic care?

The Empire Plan:

You have guaranteed access to unlimited medically necessary care when you follow Plan requirements.

NYSHIP HMOs:

Coverage is available for a specified number of days/visits each year, as long as you follow the HMO's requirements.

What if I need durable medical equipment, medical supplies or home nursing?

The Empire Plan:

You have guaranteed, paid-in-full access to medically necessary home care, equipment and supplies[1] through the Home Care Advocacy Program (HCAP) when preauthorized and arranged by the Plan.

NYSHIP HMOs:

Benefits are available and vary depending on the HMO. Benefits may require a greater percentage of cost sharing.

[1] Diabetic shoes have an annual maximum benefit of $500.

Note: These responses are generic and highlight only general differences between The Empire Plan and NYSHIP HMOs. Details for each plan are available on individual plan pages beginning on page 18 of this booklet, in the *Empire Plan Certificate* (available online or from your HBA) and in the HMO contracts (available from each HMO).

Questions & Answers

Q: Can I join The Empire Plan or any NYSHIP-approved HMO?

A: The Empire Plan is available worldwide. To enroll or continue enrollment in a NYSHIP-approved HMO, you must live or work in that HMO's service area. If you move permanently out of and/or no longer work in your HMO's service area, you must change options. See Plans by County on pages 16 and 17 and the individual HMO pages in this booklet to check the counties each HMO will serve in 2017.

Q: How do I find out which providers and hospitals participate? What if my doctor or other provider leaves my plan?

A: Check with your providers directly to see whether they participate in The Empire Plan or in a NYSHIP HMO.

For Empire Plan provider information:

- Use the online provider directories at www.cs.ny.gov/employee-benefits. Select your group if prompted, and then click on Find a Provider. **Note:** This is the most up-to-date source for provider information.
- Ask your HBA for The Empire Plan *Participating Provider Directory*. (Always check with a provider to ensure current participation.)
- Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program for the type of provider you need.

For HMO provider information:

- Visit the web sites (web site addresses are provided on the individual HMO pages in this booklet).
- Call the telephone numbers on the HMO pages in this booklet. Ask which providers participate and which hospitals are affiliated.

If you choose a provider who does not participate in your plan, check carefully whether benefits will be available to you. Ask if you need authorization to have the provider's services covered. In most circumstances, HMOs do not provide benefits for services by nonparticipating providers or hospitals. Under The Empire Plan, you have benefits for participating and nonparticipating providers.

Note: You cannot change your plan outside the Option Transfer Period if your only reason for the change is that your provider no longer participates.

Q: I have a preexisting condition. Will I have coverage if I change options?

A: Yes. Under NYSHIP, you can change your option and still have coverage for a preexisting condition. There are no preexisting condition exclusions in any NYSHIP plan. However, coverage and exclusions differ. Ask the plan you are considering about coverage for your condition.

Q: What if I retire in 2017 and become eligible for Medicare?

A: Regardless of which option you choose, as a retiree, you and your dependent must be enrolled in Medicare Parts A and B when either of you first becomes eligible for primary Medicare coverage (see page 6). Please note that your NYSHIP benefits become secondary to Medicare and that your benefits may change.

Q: I am a COBRA dependent in a Family plan. Can I switch to Individual coverage and select a different health plan than the rest of my family?

A: Yes. As a COBRA dependent, you may elect to change to Individual coverage in a plan different from the enrollee's Family coverage. During the Option Transfer Period, you may enroll in The Empire Plan or choose any NYSHIP-approved HMO in the area where you live or work.

Q: I elected the Opt-out Program in 2016. Can I switch to NYSHIP health coverage for 2017?

A: Yes. All options are available during the Option Transfer Period (see Making a Choice, page 11). However, if you decide to stay in the Opt-out Program, you must reenroll for 2017.

The Opt-Out Program — NYSHIP Code #700

An Opt-out Program is available to eligible employees who have other employer-sponsored group health benefits. If eligible, you may opt out of NYSHIP coverage in exchange for an incentive payment. **Note:** The State Opt-out Program is not available to employees of PEs; however, a PE may offer a similar option.

The annual incentive payment is $1,000 for opting out of Individual coverage or $3,000 for opting out of Family coverage. The incentive payment is prorated and credited in your biweekly paycheck throughout the year (payable only when an employee is eligible for NYSHIP coverage at the employee share of the premium). **Note:** Opt-out incentive payments increase your taxable income.

Enrollment in the Opt-out Program does not continue automatically from year to year. To be eligible for the incentive payments, you must enroll during each Option Transfer Period and attest to having other coverage for the coming plan year.

Eligibility Requirements

To be eligible for the Opt-out Program, you must:

- be a member of a group eligible for the Opt-out Program,
- have been enrolled in the Opt-out Program for the prior plan year or enrolled in a NYSHIP health plan by April 1, 2016, (or on your first date of NYSHIP eligibility if that date is later than April 1) and
- remain continuously enrolled while eligible for the employee share of the premium through the end of 2016.

To qualify for the Opt-out Program, you must be covered under an employer-sponsored group health insurance plan through other employment of your own or a plan that your spouse, domestic partner or parent has as the result of his or her employment. New York State employees cannot opt out of NYSHIP if they are covered under NYSHIP as a dependent through another NYS employee.

According to NYSHIP rules, an individual cannot be enrolled in two NYSHIP options in his or her own right. Since the Opt-out Program is considered a NYSHIP option, an individual cannot opt out through one employer and be enrolled in NYSHIP health benefits in his or her own right through another employer.

If the employee is covered as a dependent on another NYSHIP policy through a local government or public entity, he or she is only eligible for the Individual Opt-out incentive amount ($1,000).

Make sure the other employer-sponsored plan will permit you to enroll as a dependent. You are responsible for making sure your other coverage is in effect during the period you opt out of NYSHIP.

Note: Opt-out Program participation satisfies NYSHIP enrollment requirements at the time of your retirement. The Opt-out Program is not available to retirees.

Electing To Opt Out

If you are currently enrolled in NYSHIP and wish to participate in the Opt-out Program, you must elect to opt out during the annual Option Transfer Period and attest to and provide information regarding your other employer-sponsored group health benefits for the next plan year.

To elect the Opt-out Program, you must submit a completed and signed *NYS Health Insurance Transaction Form* (PS-404) and an *Opt-out Attestation Form* (PS-409). Your NYSHIP coverage will terminate at the end of the plan year, and the incentive payments will begin with the first pay period affecting coverage for 2017.

Once enrolled in the Opt-out Program, you are not eligible for the incentive payment during any period that you do not meet the requirements for the State contribution to the cost of your NYSHIP coverage. Additionally, if you are receiving the opt-out incentive for Family coverage and your last dependent loses NYSHIP eligibility, you will only be eligible for the Individual payment from that date forward.

Reminder: All options are available to you during the Option Transfer Period. If you are currently enrolled in the Opt-out Program, you may choose other NYSHIP coverage or elect to opt out again for 2017.

Plans by County

The Empire Plan

The Empire Plan is available to all enrollees in the New York State Health Insurance Program (NYSHIP). You may choose The Empire Plan regardless of where you live or work. Coverage is worldwide. See pages 18-27 for a summary of The Empire Plan.

Page in *Choices*	**18**	**28**	**30**	**32**	**32**	**32**	**34**	**34**	**34**	**36**	**36**	**36**	**38**	**38**	**40**	**42**	**42**	**42**	**42**	**42**
	The Empire Plan	Blue Choice*	BlueCross BlueShield of Western New York*	CDPHP*	CDPHP*	CDPHP*	Empire BlueCross BlueShield HMO*	Empire BlueCross BlueShield HMO*	Empire BlueCross BlueShield HMO*	HIP*	HIP	HIP	HMOBlue	HMOBlue	Independent Health*	MVP*	MVP*	MVP*	MVP*	MVP
NYSHIP Code	001	066	067	063	300	310	280	290	320	050	220	350	072	160	059	058	060	330	340	360
Albany	•			•			•				•						•			
Allegany	•		•												•					
Bronx	•							•		•										
Broome	•				•								•					•		
Cattaraugus	•		•												•					
Cayuga	•												•					•		
Chautauqua	•		•												•					
Chemung	•												•							
Chenango	•				•									•				•		
Clinton	•						•							•						•
Columbia	•			•			•				•						•			
Cortland	•												•					•		
Delaware	•					•	•					•		•				•		
Dutchess	•					•			•			•							•	
Erie	•		•												•					
Essex	•				•		•							•						•
Franklin	•													•						•
Fulton	•			•			•							•			•			
Genesee	•		•												•	•				
Greene	•			•			•				•						•			
Hamilton	•				•									•			•			
Herkimer	•				•									•				•		
Jefferson	•													•				•		
Kings	•							•		•										
Lewis	•													•				•		
Livingston	•	•														•				
Madison	•				•									•				•		
Monroe	•	•														•				
Montgomery	•			•			•							•			•			
Nassau	•							•		•										
New York	•							•		•										

* Medicare-primary NYSHIP enrollees will be enrolled in this HMO's Medicare Advantage Plan. For more information about NYSHIP Medicare Advantage Plans, ask your HBA for a copy of *2017 Choices* for Retirees.

Health Maintenance Organizations (HMOs)

Most NYSHIP enrollees have a choice among HMOs. You may enroll or continue to be enrolled in any NYSHIP-approved HMO that serves the area where you live or work. You may not be enrolled in an HMO outside your area. This list will help you determine which HMOs are available by county. The pages indicated describe benefits available from each HMO.

Page in *Choices*	**18**	**28**	**30**	**32**	**32**	**32**	**34**	**34**	**34**	**36**	**36**	**36**	**38**	**38**	**40**	**42**	**42**	**42**	**42**	**42**
	The Empire Plan	Blue Choice*	BlueCross BlueShield of Western New York*	CDPHP*	CDPHP*	CDPHP*	Empire BlueCross BlueShield HMO*	Empire BlueCross BlueShield HMO*	Empire BlueCross BlueShield HMO*	HIP*	HIP	HIP	HMOBlue	HMOBlue	Independent Health*	MVP*	MVP*	MVP*	MVP*	MVP
NYSHIP Code	001	066	067	063	300	310	280	290	320	050	220	350	072	160	059	058	060	330	340	360
Niagara	•		•												•					
Oneida	•				•									•				•		
Onondaga	•												•					•		
Ontario	•	•														•				
Orange	•					•			•			•							•	
Orleans	•		•												•	•				
Oswego	•												•					•		
Otsego	•				•									•				•		
Putnam	•								•			•							•	
Queens	•							•		•										
Rensselaer	•			•			•				•						•			
Richmond	•							•		•										
Rockland	•							•											•	
Saratoga	•			•			•				•						•			
Schenectady	•			•			•				•						•			
Schoharie	•			•			•										•			
Schuyler	•												•							
Seneca	•	•														•				
St. Lawrence	•													•						•
Steuben	•												•			•				
Suffolk	•							•		•										
Sullivan	•								•			•							•	
Tioga	•				•								•					•		
Tompkins	•												•					•		
Ulster	•					•			•			•							•	
Warren	•			•			•				•						•			
Washington	•			•			•				•						•			
Wayne	•	•														•				
Westchester	•							•		•									•	
Wyoming	•		•												•	•				
Yates	•	•														•				

* Medicare-primary NYSHIP enrollees will be enrolled in this HMO's Medicare Advantage Plan. For more information about NYSHIP Medicare Advantage Plans, ask your HBA for a copy of *2017 Choices* for Retirees.

The Empire Plan — NYSHIP Code #001

This section summarizes benefits available under each portion of The Empire Plan as of January 1, 2017.[1] You may also visit www.cs.ny.gov/employee-benefits or call toll free 1-877-7-NYSHIP (1-877-769-7447) to connect to:

Medical/Surgical Program

UnitedHealthcare

Medical and surgical coverage through:

- **Participating Provider Program** – More than 250,000 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 pays up to 100 percent of usual and customary charges for covered services. See Cost Sharing (beginning on page 20) 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 21).

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.) Guaranteed access to network benefits nationwide. Limited non-network benefits available (see the *Empire Plan Certificate/Reports* for details).

Managed Physical Medicine Program – Chiropractic treatment and physical 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), 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 BlueShield

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

- Hospital inpatient stays are covered at no cost to you.
- Hospital outpatient and emergency care are subject to network copayments.
- When you use a network hospital, 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 hospital outpatient and emergency care 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

[1] These benefits are subject to medical necessity and to limitations and exclusions described in the *Empire Plan Certificate* and *Empire Plan Reports/Certificate Amendments*.

covered services received from a non-network provider will be paid in accordance with the Basic Medical portion of the Medical/Surgical Program.

The following benefit level applies for hospital services received at **non-network hospitals** (for Empire Plan-primary enrollees only[2]):

- Non-network hospital inpatient stays and outpatient services: 10 percent coinsurance for inpatient stays and the greater of 10 percent coinsurance or $75 for outpatient services per visit, up to the combined annual coinsurance maximum per enrollee, per enrolled spouse or domestic partner, per all enrolled dependent children combined (see page 20).

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 inpatient stay:

- 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.

Mental Health and Substance Abuse Program

Beacon Health Options Inc.

The Mental Health and Substance Abuse (MHSA) Program offers two levels of benefits. If you call the MHSA Program before you receive services and follow their recommendations, you receive:

NETWORK BENEFITS

(unlimited when medically necessary)

- inpatient (paid in full)
- crisis intervention (up to three visits per crisis paid in full; after the third visit, the $20 copayment per visit applies)
- outpatient including office visits, home-based or telephone counseling and nurse practitioner services ($20 copayment)
- outpatient rehabilitation with an approved structured outpatient rehabilitation program for substance abuse ($20 copayment)

If you do **NOT** follow the requirements for network coverage, you receive:

NON-NETWORK BENEFITS[3]

(unlimited when medically necessary)

- For Practitioner Services: the MHSA 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, per all enrolled dependent children combined. After the combined annual coinsurance maximum is reached per enrollee,

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

[3] You are responsible for ensuring that MHSA Program certification is received for care obtained from a non-network practitioner or facility.

per enrolled spouse or domestic partner, per all enrolled dependent children combined, the Plan pays up to 100 percent of usual and customary charges for covered services (see page 20).

- 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, per all enrolled dependent children combined. After the coinsurance maximum is met, the Plan pays 100 percent of billed charges for covered services (see page 20).
- Outpatient treatment sessions for family members of an alcoholic, alcohol abuser or substance abuser 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 with the Plan.

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:

- MHSA Program services
- Managed Physical Medicine Program services (physical therapy and chiropractic care)
- Home Care Advocacy Program (HCAP) services (including durable medical equipment)

2017 ANNUAL MAXIMUM OUT-OF-POCKET LIMIT

Your maximum out-of-pocket expenses for in-network covered services will be $4,650 for Individual coverage and $9,300 for Family coverage for Hospital, Medical/Surgical and MHSA Programs, combined. Once you reach the limit, you will have no additional copayments.

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

COMBINED ANNUAL DEDUCTIBLE

For medical/surgical and mental health and substance abuse services, The Empire Plan has a combined annual deductible of $1,000 per enrollee, $1,000 per enrolled spouse/domestic partner and $1,000 per all dependent children combined. The combined annual deductible 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. 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.

The $1,000 combined annual deductible amount will be reduced to $500 per calendar year for employees in or equated to Salary Grade 6 or below on January 1, 2017. **Note:** This reduction is not available to judges and justices or employees of PEs.

After you satisfy the combined annual deductible, The Empire Plan pays 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 and 10 percent for non-network MHSA-approved facility services. There is no coinsurance maximum for HCAP or Managed Physical Medicine Program services.

COMBINED ANNUAL COINSURANCE MAXIMUM

The Empire Plan has a combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per enrolled spouse/domestic partner and $3,000 per all dependent children combined. After you reach the combined annual coinsurance maximum, you will be reimbursed up to 100 percent of the usual and customary charges. 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 $3,000 combined annual coinsurance maximum will be reduced to $1,500 per calendar year for employees in or equated to Salary Grade 6 or below. **Note:** This reduction is not available to judges and justices or employees of PEs.

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. 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.

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

THE EMPIRE PLAN CENTER OF EXCELLENCE PROGRAMS

The Center of Excellence for Cancer Program includes paid-in-full coverage for cancer-related expenses received through Cancer Resource Services (CRS). CRS is a nationwide network that includes many of the nation's leading cancer centers. The enhanced benefits, including a travel allowance, are available only when you are enrolled in the Program.

The Center of Excellence for Transplants Program provides paid-in-full coverage for services covered under the Program and performed at a qualified Center of Excellence. The enhanced benefits, including a travel allowance, are available only when you are enrolled in the Program and The Empire Plan is your primary coverage. Precertification is required.

The Center of Excellence for Infertility Program is a select group of participating providers recognized as leaders in reproductive medical technology and infertility procedures. Benefits are paid in full, subject to the lifetime maximum benefit of $50,000 per covered individual. A travel allowance is available. Precertification is required.

For details on the Empire Plan Centers of Excellence Programs, see the *Empire Plan Certificate/Reports* and *Reporting On Center of Excellence Programs* available at www.cs.ny.gov/employee-benefits or from your HBA.

Plan toll free at 1-877-7-NYSHIP (1-877-769-7447), choose the Medical Program and ask a representative for help. You can also visit our web site at www.cs.ny.gov/employee-benefits. Select your group if prompted, and then click on Find a Provider.

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, or ask your HBA for a copy.

Prescription Drug Program

CVS Caremark, Inc.

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 up to a 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.
- 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 and 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.
- For certain maintenance medications, you are required to fill at least two 30-day supplies using your Empire Plan Prescription Drug Program benefits before a supply for greater than 30 days will be covered. If you attempt to fill a prescription for a maintenance medication for more than a 30-day supply at a network or mail service pharmacy, the last 180 days of your prescription history will be reviewed to determine whether at least 60 days' worth of the drug was previously dispensed. If not, only a 30-day fill will be approved. This program is referred to as the New to You Program.
- 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 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.
- A pharmacist is available 24 hours a day to answer questions about your prescriptions.
- You can use a nonparticipating pharmacy or pay cash at a participating pharmacy (instead of using your Empire Plan Benefit Card) and fill out 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.

2017 ANNUAL MAXIMUM OUT-OF-POCKET LIMIT*

Your annual maximum out-of-pocket expenses for covered drugs received from a network pharmacy will be $2,500 for Individual coverage and $5,000 for Family coverage. Once you reach the limit, you will have no additional copayments for prescription drugs.

SPECIALTY PHARMACY

The Prescription Drug Program's Specialty Pharmacy Program offers 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. Choose your group, then 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.

CVS Caremark Specialty Pharmacy is the designated pharmacy for the Specialty Pharmacy Program. 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, to request refills or to speak to a specialty-trained pharmacist or nurse, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) between 7:30 a.m. and 9 p.m., Monday through Friday, Eastern time. Choose the Prescription Drug Program, and ask to speak with Specialty Customer Care.

Medicare-primary enrollees and dependents: If you are or will be Medicare primary in 2017, ask your HBA for a copy of *2017 Choices* for Retirees for information about your coverage under Empire Plan Medicare Rx, a Medicare Part D prescription drug program.

The Empire Plan Nurseline℠

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

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

Empire Plan Benefits Are Available Worldwide

The Empire Plan gives you the freedom to choose a participating provider or a nonparticipating provider.

Teletypewriter (TTY) Numbers

For callers who use a TTY device because of a hearing or speech disability. All TTY numbers are 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 annual maximum out-of-pocket limit does not apply to Empire Plan Medicare Rx.

The Empire Plan

For employees of the State of New York, Participating Employers, their enrolled dependents and for COBRA and Young Adult Option enrollees with their NYSHIP benefits.

Benefits	Network Hospital Benefits[1,2]	Participating Provider[2]	Nonparticipating Provider
Office Visits[2]		$20 per visit	Basic Medical[3]
Specialty Office Visits[2]		$20 per visit	Basic Medical[3]
Diagnostic Services:[2]			
Radiology	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Lab Tests	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Pathology	No copayment	$20 per visit	Basic Medical[3]
EKG/EEG	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Radiation, Chemotherapy, Dialysis	No copayment	No copayment	Basic Medical[3]
Women's Health Care/OB GYN:[2]			
Screenings and Maternity-Related Lab Tests	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Mammograms	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Pre/Postnatal Visits and Well-Woman Exams		$20 per visit	Basic Medical[3]
Bone Density Tests	$30[4] or $40 per outpatient visit	$20 per visit	Basic Medical[3]
Breastfeeding Services and Equipment		No copayment for pre/postnatal counseling and equipment purchase from a participating provider; one double-electric breast pump per birth	
Family Planning Services		$20 per visit	Basic Medical[3]
Infertility Services	$30[4] or $40 per outpatient visit	$20 per visit; no copayment at designated Centers of Excellence[5]	Basic Medical[3]
Contraceptive Drugs and Devices		No copayment for certain FDA-approved oral contraception methods (including outpatient surgical implantation) and counseling	Basic Medical[3]

Benefits	Network Hospital Benefits[1,2]	Participating Provider[2]	Nonparticipating Provider
Inpatient Hospital Surgery	No copayment[6]	No copayment	Basic Medical[3]
Outpatient Surgery	$40[4] or $60 per visit	$20 per visit[7]	Basic Medical[3]
Emergency Room	$60[4] or $70 per visit[8]	No copayment	Basic Medical[3,9]
Urgent Care	$30[4] or $40 per outpatient visit[10]	$20 per visit	Basic Medical[3]
Ambulance	No copayment[11]	$35 per trip[12]	$35 per trip[12]
Mental Health Practitioner Services		$20 per visit	Applicable annual deductible,[3] 80% of usual and customary; after applicable coinsurance max,[3] 100% of usual and customary (see pages 20-21 for details).
Approved Facility Mental Health Services		No copayment	90% of billed charges; after applicable coinsurance max,[3] covered in full (see pages 20-21 for details).
Outpatient Drug/ Alcohol Rehabilitation		$20 per visit to approved Structured Outpatient Rehabilitation Program	Applicable annual deductible,[3] 80% of usual and customary; after applicable coinsurance max,[3] 100% of usual and customary (see pages 20-21 for details).

1 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 page 20).

2 Copayment waived for preventive services under PPACA. See www.hhs.gov/healthcare/rights/preventive-care or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

3 See Cost Sharing (beginning on page 20) for Basic Medical information.

4 Copayment for CSEA and UCS enrollees only.

5 Certain qualified procedures require precertification and are subject to a $50,000 lifetime allowance.

6 Preadmission certification required.

7 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.)

8 Copayment waived if admitted.

9 Attending emergency room 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.

10 At a hospital-owned urgent care facility only.

11 If service is provided by admitting hospital.

12 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[1,2]	Participating Provider[2]	Nonparticipating Provider
Inpatient Drug/ Alcohol Rehabilitation		No copayment	90% of billed charges; after applicable coinsurance max,[3] covered in full (see pages 20-21 for details).
Durable Medical Equipment		No copayment (HCAP)	50% of network allowance (see the *Empire Plan Certificate/Reports*).
Prosthetics		No copayment[13]	Basic Medical[3,13] $1,500 lifetime maximum benefit for prosthetic wigs not subject to deductible or coinsurance
Orthotic Devices		No copayment[13]	Basic Medical[3,13]
External Mastectomy Prostheses		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[3,13] (precertification may be required).
Rehabilitative Care (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	Physical or occupational therapy $20 per visit (MPN) Speech therapy $20 per visit	$250 annual deductible, 50% of network allowance Basic Medical[3]
Diabetic Supplies		No copayment (HCAP)	50% of network allowance (see the *Empire Plan Certificate/Reports*).
Insulin and Oral Agents (covered under the Prescription Drug Program, subject to drug copayment)			
Diabetic Shoes		$500 annual maximum benefit	75% of network allowance up to an annual maximum benefit of $500 (see the *Empire Plan Certificate/Reports*).
Hospice	No copayment, no limit		10% of billed charges up to the combined annual coinsurance maximum

Benefits	Network Hospital Benefits[1,2]	Participating Provider[2]	Nonparticipating Provider
Skilled Nursing Facility	No copayment up to 365 benefit days[14]		
Prescription Drugs (see pages 22-23)			
Specialty Drugs (see pages 22-23)			
Additional Benefits			
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: $2,500 for the Prescription Drug Program.[15] $4,650 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Abuse Programs Family coverage: $5,000 for the Prescription Drug Program.[15] $9,300 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℠ for health information and support at 1-877-7-NYSHIP (1-877-769-7447).			
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 *Empire Plan Preventive Care Coverage Chart* on NYSHIP Online under Publications. Or, visit www.hhs.gov/healthcare/rights/preventive-care.			

1 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 page 20).

2 Copayment waived for preventive services under PPACA. See www.hhs.gov/healthcare/rights/preventive-care or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

3 See Cost Sharing (beginning on page 20) for Basic Medical information.

13 Benefit paid up to cost of device meeting individual's functional need.

14 Precertification required.

15 Does not apply to Medicare-primary enrollees.

Blue Choice
A product of Excellus BlueCross BlueShield, Rochester Region

Benefits	Enrollee Cost
Office Visits	$25 per visit ($5 for children to age 26)
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$40 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	$25 per visit
Chemotherapy	$25 for Rx injection and $25 office copayment (max two copayments per day)
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment (routine), $40 copayment (diagnostic)
Family Planning Services	$25 PCP, $40 specialist per visit
Infertility Services	Applicable physician/ facility copayment
Contraceptive Drugs	Applicable Rx copayment[1]
Contraceptive Devices	Applicable copayment/ coinsurance[1]
Inpatient Hospital Surgery	
Physician	No copayment
Facility	No copayment

Benefits	Enrollee Cost
Outpatient Surgery	
Hospital	$50 per visit
Physician's Office	$50 copayment or 20% coinsurance, whichever is less
Outpatient Surgery Facility	$40 physician and $50 facility per visit
Emergency Room (waived if admitted within 24 hours)	$100 per visit
Urgent Care Facility	$35 per visit
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$40 per visit
Group, unlimited	$40 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Physical or Occupational Therapy, max 30 visits for all outpatient services combined	$40 per visit
Outpatient Speech Therapy, max 30 visits for all outpatient services combined	$40 per visit
Diabetic Supplies up to a 30-day supply	$25 per item
Insulin and Oral Agents up to a 30-day supply	$25 per prescription
Diabetic Shoes one pair per year when medically necessary	50% coinsurance

[1] Generic oral contraceptives and certain OTC contraceptive devices are covered in full in accordance with the Affordable Care Act.

Benefits	Enrollee Cost
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days per admission, 360-day lifetime max	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1, $30 Tier 2, $50 Tier 3[2]
Mail Order, up to 90-day supply	$20 Tier 1, $60 Tier 2, $100 Tier 3[2]
You can purchase a 90-day supply of a maintenance medication at a retail pharmacy for a $30, $90 or $150 copayment. You are limited to a 30-day supply for the first fill. Coverage includes fertility drugs, injectable and self-injectable medications and enteral formulas.	
Specialty Drugs	
Designated specialty drugs are covered only at a network specialty pharmacy, subject to the same days' supply and cost-sharing requirements as the retail benefit, and cannot be filled via mail order. A current list of specialty medications and pharmacies is available at www.excellusbcbs.com.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) ..... $6,350 Individual, $12,700 Family per year

Dental[3] ..... $40 per visit

Vision[4] ..... $40 per visit

Hearing Aids ..... Children to age 19: Covered in full for up to two hearing aids every three years

Out of Area ..... Our BlueCard and Away From Home Care Programs cover routine and urgent care while traveling, for students away at school, members on extended out-of-town business and for families living apart.

Maternity
(Physician's charge for delivery) ..... $50 copayment

Plan Highlights for 2017

Laboratory and pathology services are covered in full. We deliver high-quality coverage, plus discounts on services that encourage you to keep a healthy lifestyle.

Participating Physicians

With more than 3,200 providers available, Blue Choice offers you more choice of doctors than any other area HMO. Talk to your doctor about whether Blue Choice is the right plan for you.

Affiliated Hospitals

All operating hospitals in the Blue Choice service area are available to you, plus some outside the service area. Please call the number provided for a directory, or visit www.excellusbcbs.com.

Pharmacies and Prescriptions

Fill prescriptions at any of our more than 60,000 participating pharmacies nationwide. Simply show the pharmacist your ID card. Blue Choice offers convenient mail order services for select maintenance drugs. Blue Choice offers an **incented formulary**.

Medicare Coverage

Medicare-primary NYSHIP enrollees must enroll in Medicare Blue Choice, our **Medicare Advantage Plan**. To qualify, you must be enrolled in Medicare Parts A and B and live in the service area. Some copayments will vary.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 066

A Network HMO serving individuals living or working in the following counties: Livingston, Monroe, Ontario, Seneca, Wayne and Yates.

Blue Choice

165 Court Street, Rochester, NY 14647

For information:

Blue Choice: 1-800-499-1275
TTY: 1-800-421-1220
Medicare Blue Choice: 1-877-883-9577
Website: www.excellusbcbs.com

[2] If your doctor prescribes a brand-name drug when an FDA-approved generic equivalent is available, you pay the difference between the cost of the generic and the brand-name drug, plus any applicable copayments.

[3] Coverage for accidental injury to sound and natural teeth and for care due to congenital disease or anomaly; routine care not covered.

[4] Coverage for exams to treat a disease or injury; routine care not covered.

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit
Lab Tests	No copayment[1]
Pathology	No copayment
EKG/EEG	$20 per visit
Radiation	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment (routine only)
Prenatal Visits[2]	$20 for initial visit only
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services[3]	$20 per visit
Infertility Services[4]	$20 per visit
Contraceptive Drugs[5]	No copayment[6]
Contraceptive Devices	No copayment[6]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$100 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$100 per visit
Emergency Room (waived if admitted)	$100 per visit

Benefits	Enrollee Cost
Urgent Care Facility	$35 per visit
Ambulance	$100 per trip
Outpatient Mental Health	
Individual unlimited when medically necessary	$20 per visit
Group unlimited when medically necessary	$20 per visit
Inpatient Mental Health unlimited when medically necessary	No copayment
Outpatient Drug/Alcohol Rehab unlimited when medically necessary	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited when medically necessary	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	20% coinsurance
Orthotics	20% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient Physical or Occupational Therapy, max 20 visits[7]	$20 per visit
Outpatient Speech Therapy, max 20 visits[7]	$20 per visit
Diabetic Supplies	$20 per item
Insulin and Oral Agents	$20 per item
Diabetic Shoes	Not covered
Hospice, max 210 days per year	No copayment

[1] For services at a standalone Quest lab or outpatient hospital that participates as a Quest Diagnostics hospital draw site. Lab services performed in conjunction with outpatient surgery or an emergency room visit also paid in full.

[2] One-time $20 copayment to confirm pregnancy. No copayment for inpatient maternity care or gestational diabetes screenings.

[3] Coverage is provided for diagnostic testing and procedures in conjunction with artificial insemination. The copayments, coinsurance and deductible under your policy, which apply to hospital, medical or prescription drug benefits, are applicable to the benefits covered under family planning services.

[4] For services to diagnose and treat infertility. See "Additional Benefits" for artificial insemination.

[5] Coverage is provided for prescription drugs approved by the FDA for use in treatment associated with contraception.

Benefits	Enrollee Cost
Skilled Nursing Facility max 50 days	No copayment
Prescription Drugs	
Retail, 30-day supply[6]	$5 Tier 1, $30 Tier 2, $60 Tier 3
Mail Order, 90-day supply	$12.50 Tier 1, $75 Tier 2, $150 Tier 3
Includes prenatal vitamins, fertility drugs, injectable/self-injectable medications, insulin and oral diabetic agents. May require prior approval.	
Specialty Drugs	
Available through mail order at the applicable copayment.	

Additional Benefits

Annual Out-of-Pocket Maximum (In-Network Benefits) ..... $3,000 Individual, $6,000 Family per year

Dental ..... 20% discount at select providers, free second annual exam

Vision ..... VisionPLUS Program (details below)

Hearing Aids ..... Discounts available at select locations

Out of Area ..... Worldwide coverage for emergency and urgent care through the BlueCard Program. Guest membership for routine care away from home that enables members on extended business trips or family members away at school to join a nearby Blue HMO for the same benefits.

VisionPLUS Program ..... Includes routine eye exam covered in full and participating VisionPLUS provider discounts. Low copayments on frames, lenses and a discount on contact lenses and supplies.

Artificial Insemination ..... 20% coinsurance Other artificial means to induce pregnancy (in-vitro embryo transfer, etc.) are not covered.

Wellness Services ..... $300 Wellness Card allowance for use at participating providers

Plan Highlights for 2017

Wellness programs, online and community-based. Acupuncture, massage therapy, nutritional counseling, fitness centers, spa discounts.

Participating Physicians

You have access to 3,000+ physicians/healthcare professionals.

Affiliated Hospitals

You may receive care at all western New York hospitals and other hospitals if medically necessary.

Pharmacies and Prescriptions

Our network includes 45,000 participating pharmacies. Prescriptions filled up to 30-day supply. BlueCross BlueShield offers an **incented formulary**.

Medicare Coverage

Medicare-primary enrollees are required to enroll in Senior Blue HMO. To qualify, you must enroll in Medicare Parts A and B and live in one of the counties below.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 067

An IPA HMO serving individuals living or working in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

BlueCross BlueShield of Western New York

P.O. Box 80, Buffalo, NY 14240-0080

For information:

BlueCross BlueShield of Western New York:
716-887-8840 or 1-877-576-6440

TTY: 711

Website: www.bcbswny.com

[6] No copayment for contraceptive drugs and devices unless a generic equivalent is available and you are subject to a $30 (Tier 2) or $60 (Tier 3) copayment. A mail-order supply costs 2.5 times the applicable copayment.

[7] Twenty visits in aggregate for physical therapy, occupational therapy and speech therapy.

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology	$20 per visit[1]
Lab Tests	$20 per visit[2]
Pathology	$20 per visit[2]
EKG/EEG	$20 per visit
Radiation	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs	No copayment[3]
Contraceptive Devices	No copayment[3]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$75 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$75 per visit
Emergency Room (waived if admitted within 24 hours)	$50 per visit
Urgent Care Facility	$25 per visit
Ambulance	$50 per trip

Benefits	Enrollee Cost
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics[4]	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Physical or Occupational Therapy, max 30 visits each per calendar year	$20 per visit
Outpatient Speech Therapy, max 20 visits per calendar year	$20 per visit
Diabetic Supplies	
Retail, 30-day supply	$20 per item
Mail-Order, 90-day supply	$50 per item
Insulin and Oral Agents	
Retail, 30-day supply	$20 per item
Mail-Order, 90-day supply	$50 per item
Diabetic Shoes one pair per year when medically necessary	$20 per pair
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days	No copayment

[1] Waived if provider is a preferred center.

[2] Waived if provider is a designated laboratory.

[3] OTC contraceptives with a written physician order/prescription will be reimbursed at no member cost share. OTC contraceptives without a prescription will not be covered. Non-formulary contraceptives require prior authorization to be covered at no copayment. If not approved, 100 percent member liability applies.

[4] Excludes shoe inserts.

Benefits	Enrollee Cost
Prescription Drugs	
Retail, 30-day supply	$5 Tier 1, $30 Tier 2, $50 Tier 3
Mail Order, 90-day supply	$12.50 Tier 1, $75 Tier 2, $125 Tier 3
Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas. OTC formulary drugs are subject to Tier 1 copayment. By law, generics match brand-name strength, purity and stability. Ask your doctor about generic alternatives.	
Specialty Drugs	
Certain specialty drugs, regardless of tier, require prior approval, are subject to clinical management programs and must be filled by a network specialty pharmacy. Contact Caremark Specialty Pharmacy Services at 1-800-237-2767. A representative will work with your doctor and arrange delivery. For more information, visit Rx Corner at www.cdphp.com.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) ..... $6,850 Individual, $13,700 Family per year

Dental ..... Not covered

Vision ..... Not covered

Hearing Aids ..... Not covered

Out of Area ..... Coverage for emergency care out of area. College students are also covered for preapproved follow-up care.

Allergy Injections ..... No copayment

Diabetes Self-management Education ..... $20 per visit

Glucometer ..... $20 per item

Acupuncture 10 visits per plan year ..... $20 per visit

Diabetic Prevention Program ..... No copayment
Reimbursement up to $500 per subscriber per year

Plan Highlights for 2017

CDPHP InMotion℠ is a free mobile smartphone fitness application with GPS technology to map your runs; view or share results at inmotion.cdphp.com. With Rx for Less, get deep discounts on specified generic prescriptions filled at any CVS, Walmart or Price Chopper. Dedicated member services reps are available weekdays from 8 a.m. to 8 p.m. We also have health experts who can find the best program or service for you; simply call 1-888-94-CDPHP.

Participating Physicians

CDPHP has nearly 10,000 participating practitioners and providers.

Affiliated Hospitals

CDPHP is affiliated with most major hospitals in our service area. An out-of-network facility or Center of Excellence can be approved for special care needs.

Pharmacies and Prescriptions

CDPHP offers a **closed formulary** with few excluded drugs. Log in to Rx Corner at www.cdphp.com to find participating pharmacies and view claims. Mail order saves money; find forms online or call 518-641-3700 or 1-800-777-2273.

Medicare Coverage

Medicare-primary NYSHIP retirees and dependents must enroll in CDPHP Group Medicare Rx (HMO) or Group Medicare (HMO). To qualify, you must have Medicare Parts A and B and live in one of the counties listed below.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 063

An IPA HMO serving individuals living or working in the following counties: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

NYSHIP Code Number 300

An IPA HMO serving individuals living or working in the following counties: Broome, Chenango, Essex, Hamilton, Herkimer, Madison, Oneida, Otsego and Tioga.

NYSHIP Code Number 310

An IPA HMO serving individuals living or working in the following counties: Delaware, Dutchess, Orange and Ulster.

Capital District Physicians' Health Plan, Inc. (CDPHP)

500 Patroon Creek Boulevard, Albany, NY 12206-1057

For information:

Member Services: 518-641-3700 or 1-800-777-2273

TTY: 1-877-261-1164

Website: www.cdphp.com

Empire BlueCross BlueShield
An Anthem Company

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology[1]	$20 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$20 per visit
Radiation	No copayment
Chemotherapy	No copayment
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$20 per visit
Infertility Services	$20 per visit
Contraceptive Drugs	Applicable Rx copayment[2]
Contraceptive Devices	No copayment
Inpatient Hospital Surgery[1]	No copayment
Outpatient Surgery	
Hospital	$75 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility[1]	$75 per visit

Benefits	Enrollee Cost
Emergency Room (waived if admitted within 24 hours)	$75 per visit
Urgent Care Facility	$20 per visit
Ambulance	No copayment
Outpatient Mental Health	
Individual,[1] unlimited	$20 per visit[3]
Group,[1] unlimited	$20 per visit[3]
Inpatient Mental Health[1] unlimited	No copayment
Outpatient Drug/Alcohol Rehab[1]	$20 per visit[4]
Inpatient Drug/Alcohol Rehab[1] as many days as medically necessary	No copayment
Durable Medical Equipment[1]	20% coinsurance
Prosthetics[1]	20% coinsurance
Orthotics[1]	20% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 30 days	No copayment
Outpatient Physical or Occupational Therapy[5]	$20 per visit
Outpatient Speech Therapy[5]	$20 per visit
Diabetic Supplies[6]	$20 per item
Insulin and Oral Agents[6]	$20 per item
Diabetic Shoes unlimited pairs when medically necessary	$20 per pair
Hospice 210 days maximum per lifetime	No copayment

[1] Empire's network provider must precertify in-network services or services may be denied; Empire network providers cannot bill members beyond in-network copayment (if applicable) for covered services. For ambulatory surgery, preapproval is required for cosmetic/reconstructive procedures, outpatient transplants and ophthalmological or eye-related procedures.

[2] Certain prescription contraceptives are covered in full in accordance with the Affordable Care Act. To be covered in full, the prescription must be a generic drug or brand-name drug with no generic equivalent and filled at a network pharmacy.

[3] No copayment for visits at an outpatient mental health facility.

[4] No copayment for visits in an outpatient facility.

[5] Up to 30 visits per calendar year combined between home, office or outpatient facility.

[6] For diabetic DME/supplies, copayment applies for up to 52 combined items annually, then covered at 100 percent.

Benefits	Enrollee Cost
Skilled Nursing Facility[1] 60 days maximum per calendar year	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1, $25 Tier 2, $50 Tier 3
Mail Order, 90-day supply	$20 Tier 1, $50 Tier 2, $100 Tier 3
Specialty Drugs Specialty medications only dispensed in 30-day supplies. Enrollees are required to pay the applicable copayment for each 30-day supply.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) ..... $5,080 Individual, $12,700 Family per year

Dental ..... Not covered

Vision ..... Not covered

Hearing Aids ..... Not covered

Out of Area ..... The Guest Membership Program offers temporary coverage through the local BlueCross and/or BlueShield HMO plan for contract holders away from home more than 90 days but less than 180 days and for full-time students/other eligible dependents away from home more than 90 days. The BlueCard Program covers enrollees traveling outside the service area who may encounter an urgent or emergent situation and who are not enrolled in the Guest Membership Program.

LiveHealth Online ..... $20 per visit

Plan Highlights for 2017

LiveHealth Online is a convenient way for you to interact with a doctor via live, two-way video on your computer or mobile device. Empire BlueCross BlueShield HMO provides a full range of benefits including low out-of-pocket costs. Visit www.empireblue.com for a list of your claims and payment status, email messages, your personal profile and healthcare provider information.

Participating Physicians

Our network provides access to more than 65,000 provider locations.

Affiliated Hospitals

Members are covered through a comprehensive network of area hospitals (more than 140) to which their participating physician has admitting privileges. HMO members may be directed to other hospitals to meet special needs. See our web site for a list of all participating hospitals.

Pharmacies and Prescriptions

Enrollees with prescription coverage can use local and national pharmacies. Members who use our mail service pay only two copayments for each 90-day supply of medication. Coverage includes contraceptive drugs and devices, injectable and self-injectable drugs, fertility drugs and enteral formulas. Empire BlueCross BlueShield HMO offers an **incented formulary**.

Medicare Coverage

Medicare-primary enrollees are required to enroll in MediBlue, the Empire BlueCross BlueShield **Medicare Advantage Plan**. To qualify, you must be enrolled in Medicare Parts A and B and live in one of the counties listed below.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 280

An IPA HMO serving individuals living or working in the following counties: Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

NYSHIP Code Number 290

An IPA HMO serving individuals living or working in the following counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk and Westchester.

NYSHIP Code Number 320

An IPA HMO serving individuals living or working in the following counties: Dutchess, Orange, Putnam, Sullivan and Ulster.

Empire BlueCross BlueShield HMO

11 Corporate Woods Boulevard, P.O. Box 11800
Albany, NY 12211-0800

For information:

Empire BlueCross BlueShield HMO: 1-800-453-0113
For Medicare Advantage Plan Preenrollment Information: 1-866-205-6551
TTY: 1-800-241-6894
Website: www.empireblue.com

HIP®
HEALTH PLAN OF NEW YORK
an EmblemHealth Company

Benefits	Enrollee Cost
Office Visits	$5 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$10 per visit
Diagnostic/Therapeutic Services	
Radiology	No copayment
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	No copayment
Chemotherapy	$10 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$5 PCP, $10 specialist per visit
Infertility Services	$10 per visit
Contraceptive Drugs[1]	No copayment
Contraceptive Devices[1]	No copayment
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	No copayment
Physician's Office	$5 PCP, $10 specialist per visit
Outpatient Surgery Facility	No copayment
Emergency Room (waived if admitted)	$75 per visit
Urgent Care Facility	$5 copayment
Ambulance	No copayment
Outpatient Mental Health unlimited	No copayment

Benefits	Enrollee Cost
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$5 PCP, $10 specialist per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	No copayment
Prosthetics	No copayment
Orthotics	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 30 days	No copayment
Outpatient Physical or Occupational Therapy, max 90 visits for all outpatient rehabilitative care	$10 per visit
Outpatient Speech Therapy, max 90 visits for all outpatient rehabilitative care	$10 per visit
Diabetic Supplies	$5 per 34-day supply
Insulin and Oral Agents	$5 per 34-day supply
Diabetic Shoes[2] when medically necessary	No copayment
Hospice, max 210 days	No copayment
Skilled Nursing Facility unlimited	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 Tier 1, $20 Tier 2
Mail Order, 90-day supply	$7.50 Tier 1, $30 Tier 2
Subject to drug formulary, includes fertility drugs, injectable and self-injectable medications and enteral formulas. Copayments reduced by 50 percent when utilizing EmblemHealth mail order service. Up to a 90-day supply of generic or brand-name drugs may be obtained.	

[1] Covered for FDA-approved contraceptive drugs and devices only.

[2] Precertification must be obtained from the participating vendor prior to purchase.

Specialty Drugs

Coverage provided through EmblemHealth Specialty Pharmacy Program. Specialty drugs include injectables and oral agents that are more complex to administer, monitor and store in comparison with traditional drugs. Specialty drugs require prior approval, which can be obtained by the HIP prescribing physician. Specialty drugs are subject to the applicable Rx copay, Rx formulary and distribution from our preferred specialty pharmacy.

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) ..... $6,850 Individual, $13,700 Family per year

Dental ..... Not covered

Vision ..... No copayment

Hearing Aids ..... Cochlear implants only

Out of Area ..... Covered for emergency services only

Eyeglasses ..... $35 per pair
one pair every 24 months for selected frames

Laser Vision Correction (LASIK) ..... Discount program

Fitness Program ..... Discount program

Alternative Medicine Program ..... Discount program

Artificial Insemination ..... $10 per visit

Prostate Cancer Screening ..... No copayment

Dialysis Treatment ..... $10 per visit

Plan Highlights for 2017

The HIP Prime network has more than 39,000 physicians practicing in 105,000 locations and an overall network of 71,000 providers in more than 168,000 locations. HIP (an EmblemHealth company) has been providing health benefits to hardworking New Yorkers for nearly seven decades and is committed to building a healthy future for you and your family. More information is available at www.emblemhealth.com.

Participating Physicians

The HIP Prime network offers the choice of a traditional network of independent physicians who see patients in their own offices, as well as providers in physician group practices that meet most, if not all, of a member's medical needs under one roof. Group practices offer services in most major specialties such as cardiology and ophthalmology, plus ancillary services like lab tests, X-rays and pharmacy services.

Affiliated Hospitals

HIP Prime members have access to more than 100 of the area's leading hospitals, including major teaching institutions.

Pharmacies and Prescriptions

Filling a prescription is easy with more than 40,000 participating pharmacies nationwide, including more than 4,700 participating pharmacies throughout New York State. HIP Prime members have access to a mail order program through Express Scripts. The HIP Prime Plan offers a **closed formulary**. Tier 1 includes generic drugs; Tier 2 includes brand-name drugs.

Medicare Coverage

Retirees who are not Medicare-eligible are offered the same coverage as active employees. Medicare-primary retirees who reside in NYSHIP-approved downstate service counties are required to enroll in the VIP Premier (HMO) Medicare Plan, a **Medicare Advantage Plan** that provides Medicare benefits and more.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 050

A Network and IPA HMO serving individuals living or working in the following counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester.

NYSHIP Code Number 220

An IPA HMO serving individuals living or working in the following counties: Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington.

NYSHIP Code Number 350

An IPA HMO serving individuals living or working in the following counties: Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster.

EmblemHealth

55 Water Street, New York, NY 10041

For information:

Customer Service: 1-800-447-8255

TTY: 1-888-447-4833

Website: www.emblemhealth.com

HMOBlue

A product of Excellus BlueCross BlueShield

An Independent Licensee of the BlueCross BlueShield Association

Benefits	Enrollee Cost
Office Visits	$25 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$40 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	$25 per visit
Chemotherapy	$25 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	$25 per visit
Family Planning Services	$25 PCP, $40 specialist per visit
Infertility Services	Applicable physician/ facility copayment
Contraceptive Drugs	Applicable Rx copayment[1]
Contraceptive Devices	Applicable copayment/ coinsurance[1]
Inpatient Hospital Surgery	
Physician	$200 copayment or 20% coinsurance, whichever is less
Facility	No copayment
Outpatient Surgery	
Hospital	$40 physician copayment per visit
Physician's Office	$50 copayment or 20% coinsurance, whichever is less
Outpatient Surgery Facility	$50 per visit
Emergency Room (waived if admitted)	$100 per visit

Benefits	Enrollee Cost
Urgent Care Facility	$35 per visit
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$40 per visit
Group, unlimited	$40 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 60 days	No copayment
Outpatient Physical or Occupational Therapy, max 30 visits for all outpatient services combined	$40 per visit
Outpatient Speech Therapy, max 30 visits for all outpatient services combined	$40 per visit
Diabetic Supplies 30-day supply	$25 per item
Insulin and Oral Agents 30-day supply	$25 per item
Diabetic Shoes three pairs per year when medically necessary	50% coinsurance
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days per calendar year	No copayment

[1] Generic oral contraceptives and certain OTC contraceptive devices covered in full in accordance with the Affordable Care Act.

Benefits	Enrollee Cost
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1, $30 Tier 2, $50 Tier 3[2]
Mail Order, 90-day supply	$20 Tier 1, $60 Tier 2, $100 Tier 3[2]
Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas.	
Specialty Drugs	
Specialty medications after the initial first fill must be purchased from one of our participating specialty pharmacies. A current list of specialty medications and pharmacies is available on our web site.	

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) ..... $6,350 Individual, $12,700 Family per year

Dental ..... Not covered

Vision ..... $40 per visit for eye exams associated with disease or injury

Hearing Aids ..... Children to age 19: Covered in full for up to two hearing aids every three years; $40 copayment per visit for fittings

Out of Area ..... The BlueCard and Away From Home Care Programs provide routine and urgent care coverage while traveling, for students away at college, members on extended out-of-town business and families living apart.

Hearing Exam ..... $40 per visit for routine (once every 12 months) and diagnostic

Maternity
(Physician charge for delivery) ..... $200 copayment or 20% coinsurance, whichever is less

Smoking Cessation ..... The Quit For Life program is an award-winning support program to help you quit using tobacco for good. Call 1-800-442-8904 or go to www.quitnow.net/Excellus for more information.

Plan Highlights for 2017

All laboratory and pathology services are covered in full. No referrals required. Routine preventive services, such as adult physicals, mammograms, pap smears, prostate screenings and routine adult immunizations are covered in full.

Participating Physicians

HMOBlue is affiliated with more than 4,700 physicians and health care professionals.

Affiliated Hospitals

All hospitals within our designated service area participate with HMOBlue. Members may be directed to other hospitals to meet special needs when medically necessary.

Pharmacies and Prescriptions

HMOBlue members may purchase prescription drugs from more than 60,000 participating FLRx Network pharmacies nationwide. We offer an **incented formulary**.

Medicare Coverage

HMOBlue offers the same benefits to Medicare-eligible NYSHIP enrollees. HMOBlue **coordinates coverage** with Medicare.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 072

An IPA HMO serving individuals living or working in the following counties: Broome, Cayuga, Chemung, Cortland, Onondaga, Oswego, Schuyler, Steuben, Tioga and Tompkins.

NYSHIP Code Number 160

An IPA HMO serving individuals living or working in the following counties: Chenango, Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego and St. Lawrence.

Excellus BlueCross BlueShield

HMOBlue 072
333 Butternut Drive, Syracuse, NY 13214-1803

Excellus BlueCross BlueShield

HMOBlue 160
12 Rhoads Drive, Utica, NY 13502

For information:

HMOBlue Customer Service: 1-800-499-1275
TTY: 1-800-421-1220
Website: www.excellusbcbs.com

[2] If a doctor selects a brand-name drug (Tier 2 or Tier 3) when an FDA-approved generic equivalent is available, the benefit will be based on the generic drug's cost, and the member will have to pay the difference, plus any applicable copayments. If your prescription has no approved generic available, your benefit will not be affected.

Benefits	Enrollee Cost
Office Visits	$20 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$20 per visit
Diagnostic/Therapeutic Services	
Radiology[1]	$20 per visit
Lab Tests[2]	$10 per visit
Pathology	$10 per visit
EKG/EEG	$20 per visit
Radiation[1]	$20 per visit
Chemotherapy	$20 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$20 per visit
Infertility Services	
Physician Office	$20 per visit
Outpatient Surgery Facility	$100 per visit
Contraceptive Drugs	Applicable Rx copayment[3]
Contraceptive Devices	Applicable Rx copayment[3]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$100 per visit
Physician's Office	$20 per visit
Outpatient Surgery Facility	$100 per visit
Emergency Room (waived if admitted within 24 hours)	$100 per visit

Benefits	Enrollee Cost
Urgent Care Facility	$35 per visit[4]
Ambulance	$100 per trip
Outpatient Mental Health	
Individual, unlimited	$20 per visit
Group, unlimited	$20 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$20 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	No copayment
Orthotics[5]	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 45 days	No copayment
Outpatient Physical or Occupational Therapy, max 20 visits per year for all outpatient services combined	$20 per visit
Outpatient Speech Therapy, max 20 visits per year for all outpatient services combined	$20 per visit
Diabetic Supplies	
Retail, 90-day supply	$20 per item
Mail Order	Not available
Insulin and Oral Agents	$20 per item or applicable Rx copayment, whichever is less
Diabetic Shoes	No copayment one pair per year when medically necessary
Hospice, unlimited	No copayment

[1] Office based: $20 copayment; hospital based: $40 copayment

[2] No copayment for lab tests drawn and processed in a primary care or specialist setting.

[3] Copayment applies only for select Tier 3 oral contraceptive drugs and devices.

[4] Within the service area. Outside the service area: $20 copayment, plus the difference in cost between Independent Health's payment and the provider's charges, if any. $35 per visit to a participating After Hours Care Facility.

[5] Excludes shoe inserts.

Benefits	Enrollee Cost
Skilled Nursing Facility max 45 days	No copayment
Prescription Drugs	
Retail, 30-day supply	$5 Tier 1, $30 Tier 2, $60 Tier 3
Mail Order, 90-day supply	$12.50 Tier 1, $75.00 Tier 2, $150 Tier 3
Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas.	
Specialty Drugs	
Benefits are provided for specialty drugs by two contracted specialty pharmacy vendors, Reliance Rx Pharmacy and Walgreens Specialty Pharmacy. Specialty drugs, available through the prescription drug benefit, include select high-cost injectables and oral agents such as oral oncology drugs. Specialty drugs require prior approval and are subject to the applicable Rx copayment based on the formulary status of the medication. Members pay one copayment for each 30-day supply.	

Additional Benefits

Annual Out-of-Pocket Maximum (In-Network Benefits) ..... $4,000 Individual, $8,000 Family per year

Dental ..... $50 per cleaning and 20% discount on additional services at select providers (preventive only)

Vision ..... $10 per visit once every 12 months (routine only)

Hearing Aids ..... Discounts available at select locations

Out of Area ..... While traveling outside the service area, members are covered for emergency and urgent care situations only.

Home Health Care, max 40 visits ..... $20 per visit

Eyeglasses ..... Discounts available

Urgent Care in Service Area for After Hours Care ..... $35 per visit

Wellness Services ..... $275 allowance for use at a participating facility

Plan Highlights for 2017

Independent Health has led the way in providing western New York with innovative solutions that set the standard for quality and service for health plans. We've consistently earned top ratings from NCQA, which is why you can feel comfortable and confident choosing us for your health coverage needs.

Participating Physicians

Independent Health is affiliated with more than 4,000 physicians and health care providers throughout the eight counties of western New York.

Affiliated Hospitals

Independent Health members are covered at all western New York hospitals and may be directed to other hospitals when medically necessary.

Pharmacies and Prescriptions

All retail pharmacies in western New York participate. Members may obtain prescriptions out of the service area by using our National Pharmacy Network, which includes 58,000 pharmacies nationwide.

Medicare Coverage

Medicare-primary NYSHIP retirees must enroll in Medicare Encompass, a **Medicare Advantage Plan**. Copayments differ from the copayments of a NYSHIP-primary enrollee. Call for detailed information.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 059

An IPA HMO serving individuals living or working in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Independent Health

511 Farber Lakes Drive, Buffalo, NY 14221

For information:

Customer Service: 1-800-501-3439

TTY: 716-631-3108

Website: www.independenthealth.com

Benefits	Enrollee Cost
Office Visits	$25 per visit ($10 for children)[1]
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$40 per visit
Diagnostic/Therapeutic Services	
Radiology	$25 per visit
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$25 per visit
Radiation	$40 per visit
Chemotherapy	$40 per visit
Women's Health Care/OB GYN	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Family Planning Services	$25 PCP, $40 specialist per visit
Infertility Services	$25 PCP, $40 specialist per visit
Contraceptive Drugs[2]	No copayment[3]
Contraceptive Devices[2]	No copayment[3]
Inpatient Hospital Surgery	No copayment
Outpatient Surgery	
Hospital	$40 per visit
Physician's Office	$25 PCP, $40 specialist per visit
Outpatient Surgery Facility	$40 per visit
Emergency Room (waived if admitted)	$75 per visit
Urgent Care Facility	$25 per visit
Ambulance	$50 per trip

Benefits	Enrollee Cost
Outpatient Mental Health	
Individual, unlimited	$25 per visit
Group, unlimited	$25 per visit
Inpatient Mental Health unlimited	No copayment
Outpatient Drug/Alcohol Rehab unlimited	$25 per visit
Inpatient Drug/Alcohol Rehab unlimited	No copayment
Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max 2 months per condition	No copayment
Outpatient Physical or Occupational Therapy, max 30 visits for all outpatient services combined	$40 per visit
Outpatient Speech Therapy, max 30 visits for all outpatient services combined	$40 per visit
Diabetic Supplies 31-day supply	$25 per boxed item
Insulin and Oral Agents 31-day supply	$25 per boxed item
Diabetic Shoes unlimited pairs when medically necessary	50% coinsurance
Hospice, max 210 days	No copayment
Skilled Nursing Facility max 45 days/calendar year	No copayment
Prescription Drugs	
Retail, 30-day supply	$10 Tier 1, $30 Tier 2, $50 Tier 3
Mail Order, 90-day supply	$25 Tier 1, $75 Tier 2, $125 Tier 3

[1] PCP sick visits for children (newborn up to age 26) $10 per visit.

[2] Over-the-counter contraceptives are not covered.

[3] Brand-name contraceptives with generic equivalents require member payment of the difference in cost between the generic and brand-name drugs, plus the Tier 1 copayment.

Prescription Drugs, *continued*

If a member requests a brand-name drug to the prescribed generic drug, he/she pays the difference between the cost of the generic and the brand-name drug, plus the Tier 1 copayment. Coverage includes fertility, injectable and self-injectable medications and enteral formulas. Approved prescription generic contraceptive drugs and devices and those without a generic equivalent are covered at 100 percent under retail and mail order.

Specialty Drugs

MVP uses CVS Caremark for specialty pharmacy services. Copayments are listed under the Prescription Drug benefit.

Additional Benefits

Annual Out-of-Pocket Maximum
(In-Network Benefits) ..... $6,350 Individual, $12,700 Family per year

Dental ..... $25 per preventive visit (children to age 19)

Vision ..... $25 per exam every 24 months (routine only)

Hearing Aids ..... Not covered

Out of Area ..... While traveling outside the service area, coverage is provided for emergency situations only.

Plan Highlights for 2017

Each MVP subscriber receives $100 HealthDollars to spend on health, wellness and fitness programs. No referrals required. As an MVP member, you can enjoy significant savings on a wide variety of health-related items, plus special discounts on LASIK eye surgery, eyewear and alternative medicine.

Participating Physicians

MVP Health Care provides services through more than 28,500 participating physicians and health practitioners located throughout its service area.

Affiliated Hospitals

MVP members are covered at participating area hospitals to which their MVP physician has admitting privileges. MVP members may be directed to other hospitals to meet special needs when medically necessary upon prior approval from MVP.

Pharmacies and Prescriptions

Virtually all pharmacy "chain" stores and many independent pharmacies within the MVP service area participate with MVP. Also, MVP offers convenient mail order service for select maintenance drugs. MVP offers an **incented formulary**.

Medicare Coverage

Medicare-primary NYSHIP enrollees must enroll in the MVP Gold Plan, MVP Health Care's **Medicare Advantage Plan**. Some of the MVP Gold Plan's copayments may vary from the MVP HMO plan's copayments. The MVP HMO plan **coordinates coverage** with Medicare in the North Region (360). Please contact Member Services for further details.

Important Note: Only participating providers in the NYS counties listed below are part of this HMO's network within NYSHIP. Before receiving care, please be sure to check that your provider participates with this HMO's NYSHIP network.

NYSHIP Code Number 058

An IPA HMO serving individuals living or working in the following counties: Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates.

NYSHIP Code Number 060

An IPA HMO serving individuals living or working in the following counties: Albany, Columbia, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

NYSHIP Code Number 330

An IPA HMO serving individuals living or working in the following counties: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins.

NYSHIP Code Number 340

An IPA HMO serving individuals living or working in the following counties: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester.

NYSHIP Code Number 360

An IPA HMO serving individuals living or working in the following counties: Clinton, Essex, Franklin and St. Lawrence.

MVP Health Care

P.O. Box 2207, 625 State Street
Schenectady, NY 12301-2207

For information:

Customer Service: 1-888-MVP-MBRS (687-6277)
TTY: 1-800-662-1220
Website: www.mvphealthcare.com

NYSHIP Online

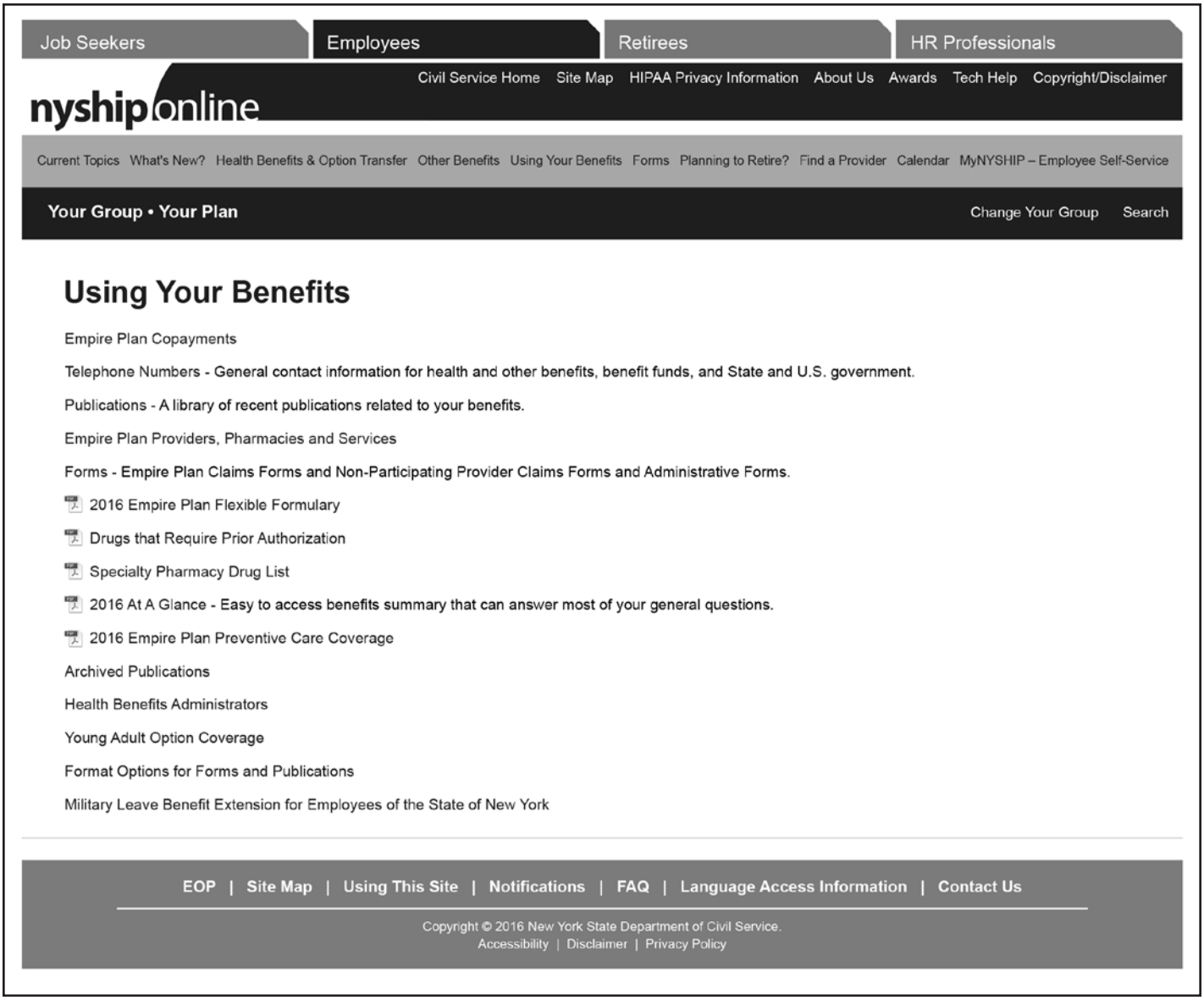
NYSHIP Online is designed to provide you with targeted information about your NYSHIP benefits. Visit the New York State Department of Civil Service web site at www.cs.ny.gov/employee-benefits and select your group and plan, if prompted.

Ask your HBA for a copy of the NYSHIP Online flyer, which provides helpful navigation information.

Reminder: If you are an active employee of New York State and a registered user of MyNYSHIP, you may change your option online (excluding the Opt-out Program) during the Option Transfer Period. See your HBA if you have questions.

How to Find Answers to Your Benefit Questions and Gain Access to Additional Important Information

- If you are an active employee, contact your HBA (usually located in your agency's Personnel Office or the Business Services Center).
- If you have questions regarding health insurance claims for The Empire Plan, call 1-877-7-NYSHIP (1-877-769-7447) toll free and choose the appropriate program on the main menu. HMO enrollees should contact their HMOs directly.
- A comprehensive list of contact information for HBAs, HMOs, government agencies, Medicare and other important resources is available on NYSHIP Online in the Using Your Benefits section.



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NYSHIP
New York State
Health Insurance Program

2017 Health Insurance Choices (Actives) – October 2016

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

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The New York State Department of Civil Service, which administers NYSHIP, produced this booklet in cooperation with NYSHIP administrators and Joint Labor/Management Committees on Health Benefits.

Care has been taken to ensure the accuracy of the material contained in this booklet. However, the HMO contracts and the *Empire Plan Certificate of Insurance* with Amendments are the controlling documents for benefits available under NYSHIP.