NYSHIP
New York State
Health Insurance Program

2021 NYSHIP Benefit Plan Comparison

Program	The Empire Plan		The Excelsior Plan	
Hospital Benefits[1]	**Network Providers/Facilities**	**Non-Network Providers/Facilities**	**Network Providers/Facilities**	**Non-Network Providers/Facilities**
Inpatient Services, including diagnostic and therapeutic services or surgical care (Preadmission Certification Required)	No copayment	Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum.[2] When the combined annual coinsurance maximum is satisfied, benefits are provided at network levels.	$250 copayment per admission. A maximum of four inpatient copayments per enrollee, per enrolled spouse/domestic partner and per all dependent children combined each calendar year.	No coverage in a non-network hospital. Exceptions apply in emergencies or when there is no network hospital within 30 miles of your residence or when no network hospital within 30 miles of your residence can provide the service you require. In these cases, network benefits are provided.
Skilled Nursing Facility Care provided in lieu of hospitalization (No coverage if Medicare-primary)	No copayment		No copayment	
Hospice Care	No copayment		No copayment	
Outpatient Services, including Preadmission Testing, Chemotherapy, Radiation Therapy, Dialysis, Pathology and Anesthesiology	No copayment	Coinsurance of 10 percent of billed charges or $75 (whichever is greater), per visit up to combined annual coinsurance maximum.[2] When the combined annual coinsurance maximum is satisfied, benefits are provided at network levels.	No copayment	
Diagnostic Radiology and Laboratory Tests; Urgent Care Center Visit	$50 copayment per visit		$85 copayment per visit	
Outpatient Surgery	$95 copayment per visit		$130 copayment per visit	
Physical Therapy following hospitalization or related surgery	$25 copayment per visit		$35 copayment per visit	
Emergency Department Visit	$100 copayment (waived if admitted)	Network coverage applies	$130 copayment (if admitted, only the inpatient copayment applies)	Network coverage applies
Medical/Surgical Benefits[1]	**Participating Providers**	**Nonparticipating Providers**	**Participating Providers**	**Nonparticipating Providers**
Office Visits/Office Surgery	$25 copayment per visit. No copayment for routine prenatal and post-natal care, well-child care, preventive care and screenings, FDA-approved contraceptive methods for women, immunizations and breast pumps.[1]	Basic Medical Program: After the combined annual deductible is met, Plan pays 80 percent of the usual and customary rate for covered services.[3] After combined annual coinsurance maximum is met, Plan considers 100 percent of the usual and customary rate for covered services.[2]	$35 copayment per visit. No copayment for prenatal visits, well-child care, preventive care and screenings, including certain FDA-approved contraceptive methods for women, immunizations and breast pumps.	Basic Medical Program: After the combined annual deductible is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined annual coinsurance maximum is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]
Non-hospital Urgent Care Center Visit	$30 copayment		$40 copayment	
Diagnostic Laboratory Tests, Diagnostic Radiology and Imaging Services (certain Radiology procedures are subject to a Prospective Procedure Review to precertify benefits)	$25 copayment per visit for all lab and radiology services performed during the visit.		Single $35 copayment for all covered services provided during the visit by a participating laboratory. $80 copayment for MRI, MRA, CT Scan, PET Scan and Nuclear Medicine test.	
Routine Pediatric Care	No copayment		No copayment	
Routine Newborn Care	No copayment	Covered and not subject to deductible or coinsurance	No copayment	Covered and not subject to deductible or coinsurance
Annual Routine Health Exams	No copayment for covered preventive routine health exams. One or more additional copayments may apply if other services are provided during the visit.	Routine health exams are covered for you, the active employee, if you are age 50 or older and for your covered spouse/domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance.	No copayment for covered preventive routine health exams. Other covered services subject to applicable copayment.	Basic Medical Program benefits for an active employee age 50 or older. This benefit is not subject to deductible or coinsurance. There is no Basic Medical coverage for routine health exams for covered dependents (spouse/domestic partner, dependent children), retirees, vestees or dependent survivors.
Adult Immunizations	$25 copayment[1,5]	No coverage	$35 copayment[1,5]	No coverage
Outpatient Surgical Locations	$50 copayment	Basic Medical Program benefits	$95 copayment per visit	Basic Medical Program benefits
Licensed Ambulance Service	$70 copayment		$70 copayment	
Prostheses and Orthotic Devices that meet the individual's functional needs	No copayment	Basic Medical Program benefits	No copayment	Basic Medical Program benefits

[1] No charge for preventive care services in accordance with the Patient Protection and Affordable Care Act (PPACA) when using Empire Plan participating providers or network facilities.
[2] Coinsurance amounts incurred for non-network Hospital coverage, Basic Medical Program coverage and non-network Mental Health and Substance Abuse Program coverage count toward the combined annual coinsurance maximum for The Empire Plan.
[3] Deductible amounts for The Empire Plan and the Excelsior Plan are shared among the Basic Medical Program and non-network coverage under the Home Care Advocacy Program and the Mental Health and Substance Abuse Program.
[4] Coinsurance amounts incurred for Basic Medical Program coverage and non-network Mental Health and Substance Abuse Program coverage count toward the combined annual coinsurance maximum for the Excelsior Plan.
[5] Certain preventive adult immunizations are covered in full. Select vaccines will be paid in full when administered by a licensed pharmacist in a network pharmacy, as well as when administered by a network physician during an office visit.

Program	The Empire Plan		The Excelsior Plan	
Medical/Surgical Benefits	**Participating Providers**	**Nonparticipating Providers**	**Participating Providers**	**Nonparticipating Providers**
External Mastectomy Prostheses	Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.		Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.	
Chiropractic Treatment, Physical Therapy and Occupational Therapy	$25 copayment per visit. $25 copayment for radiology and diagnostic laboratory services provided during the visit (maximum of two copayments per visit).	The Plan pays up to 50 percent of the network allowance after you meet an annual deductible of $250 per enrollee, $250 per enrolled spouse/domestic partner, $250 per all dependent children combined. There is no coinsurance maximum.	Single $35 copayment per visit for all covered services provided during the visit and billed by the provider.	No coverage
Home Care Services, Skilled Nursing Services and Durable Medical Equipment/Supplies	No copayment when precertified through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After the combined annual deductible is met, Plan pays up to 50 percent of HCAP network allowance. There is no coinsurance maximum.	No copayment when precertified through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After the combined annual deductible is met, Plan pays up to 50 percent of HCAP network allowance. There is no coinsurance maximum.
Mental Health and Substance Abuse Benefits[6]	**Network Providers/Facilities**	**Non-Network Providers/Facilities**	**Network Providers/Facilities**	**Non-Network Providers/Facilities**
Covered Inpatient Services (Precertification is required)	No copayment	Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum.[2] When combined coinsurance maximum is satisfied, benefits are provided at network level.	$250 copayment per admission. A maximum of four inpatient copayments per enrollee, per enrolled spouse/domestic partner and per all dependent children combined each calendar year.	No coverage in a non-network hospital. Exceptions apply in emergencies or when there is no network hospital within 30 miles of your residence or when no network hospital within 30 miles of your residence can provide the service you require. In these cases, network benefits are provided.
Inpatient Practitioner Treatment or Consultation	No copayment	After the combined annual deductible is met, the Plan pays 80 percent of the usual and customary rate for covered services.[3] After the combined annual coinsurance maximum is reached, the Plan pays 100 percent of the usual and customary rate for covered services.[2]	No copayment	After the combined annual deductible is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined annual coinsurance maximum is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]
Office Visits and other Outpatient Services	Up to three visits per crisis are paid in full for mental health treatment; additional visits may be subject to a $25 copayment.		Up to three visits per crisis are paid in full for mental health treatment; additional visits are subject to a $35 copayment.	
Emergency Department Visit	$100 copayment (waived if admitted as inpatient directly from the emergency department)	Network coverage applies	$130 copayment waived (if admitted as inpatient directly from the emergency department)	Network coverage applies
Licensed Ambulance Service	No copayment when transported to a facility for medically necessary mental health or substance use care.		$70 copayment when transported to a facility for medically necessary mental health or substance use care.	
Annual Out-of-Pocket Costs[7]				
Combined Annual Deductible	$1,250 per enrollee, $1,250 per enrolled spouse/domestic partner, $1,250 per all dependent children combined		$1,500 per enrollee, $1,500 per enrolled spouse/domestic partner, $1,500 per all dependent children combined	
Combined Annual Coinsurance Maximum	$3,750 per enrollee, $3,750 per enrolled spouse/domestic partner, $3,750 per all dependent children combined		$4,750 per enrollee, $4,750 per enrolled spouse/domestic partner, $4,750 per all dependent children combined	
Prescription Drug Program[5,8,9,10]				
	Empire Plan		**Excelsior Plan**	
	Mail Service Pharmacy and Designated Specialty Pharmacy	**Network Pharmacy**	**Mail Service Pharmacy and Designated Specialty Pharmacy**	**Network Pharmacy**
Level 1	(most generics)		(most generics)	
Up to 30 Days	$5	$5	$10	$10
31- to 90- Days	$5	$10	$25	$30
Level 2	(Preferred Drugs)		(Preferred Drugs)	
Up to 30 Days	$30	$30	$45	$45
31- to 90- Days	$55	$60	$100	$100
Level 3	(all other covered drugs)		(all other covered drugs)	
Up to 30 Days	$60	$60	$85	$85
31- to 90- Days	$110	$120	$200	$200

[6] Precertification is required for some mental health and substance use services.
[7] The Maximum Out-of-Pocket Limit for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs is $5,550 for Individual coverage and $11,100 for Family coverage for both the Empire and Excelsior Plans.
[8] The Maximum Out-of-Pocket Limit for in-network expenses incurred under the Prescription Drug Program is $3,000 for Individual coverage and $6,000 for Family coverage for both the Empire and Excelsior Plans. This does not apply to Medicare-primary Empire Plan enrollees and their covered dependents.
[9] If the enrollee's doctor believes a brand-name drug is medically necessary, the enrollee may appeal the mandatory generic substitution. If approved, Level 3 copayment applies and ancillary fee is waived. There is no generic appeal under the Excelsior Plan.
[10] Certain drugs require prior authorization and/or have quantity limit specifications.