NYSHIP
New York State Health Insurance Program

2015 NYSHIP Benefit Plan Comparison

Program	THE EMPIRE PLAN		THE EXCELSIOR PLAN SM — AN EMPIRE PLAN OPTION	
Hospital Benefits[1]	**Network Providers/Facilities**	**Non-Network**	**Network Providers/Facilities**	**Non-Network**
Inpatient Services, including diagnostic and therapeutic services or surgical care (Preadmission Certification Required)	No copayment	Not subject to deductible. Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum.[2] When the combined 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 Chemotherapy, Radiation Therapy, Dialysis and Preadmission Testing	No copayment	Not subject to deductible. Coinsurance of 10 percent of billed charges or $75 (whichever is greater) up to combined annual coinsurance maximum.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels.	No copayment	
Diagnostic Radiology and Laboratory Services	$40 copayment per visit		$75 copayment per visit	
Outpatient Surgery	$60 copayment per visit		$100 copayment per visit	
Physical Therapy following hospitalization or related surgery	$20 copayment		$30 copayment	
Emergency Department Visit	$70 copayment (waived if admitted)	Network coverage applies	$100 copayment (if admitted, only the inpatient copayment applies)	Network coverage applies
Medical/Surgical Benefits[1]	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
Office Visits/Office Surgery	$20 copayment per visit No copayment for prenatal visits, well child care, preventive care including certain contraceptives, screenings, immunizations and breast pumps.	Basic Medical Program: After the combined annual deductible is met, Plan pays 80 percent of reasonable and customary charges for covered services.[3] After combined coinsurance maximum is met, Plan pays 100 percent of reasonable and customary charges.[2]	$30 copayment per visit No copayment for prenatal visits, well child care, preventive care including certain contraceptives, screenings, 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 coinsurance maximum is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]
Diagnostic Laboratory Services, Diagnostic Radiology and Imaging Services (Certain Radiology procedures are subject to a Prospective Procedure Review to precertify benefits)	$20 copayment per visit for all lab and radiology performed during the visit.		Single $30 copayment for all covered services provided during the visit by a participating laboratory. $75 copayment for MRI, MRA, CT Scan, PET Scan and Nuclear Medicine test.	
Routine Pediatric Care	No copayment	Basic Medical Program benefits	No copayment	Basic Medical Program benefits
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 over and for your spouse or 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 $30 copayment per visit.	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 spouses, retirees, vestees or dependent survivors.
Adult Immunizations	$20 copayment[1,5]	No coverage	$30 copayment[1,5]	No coverage
Outpatient Surgical Locations	$30 copayment	Basic Medical Program benefits	$75 copayment per visit	Basic Medical Program benefits
Emergency Ambulance Service	$35 copayment		$35 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] Certain preventive care services are provided at no cost from 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 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, 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 coverage count toward the combined annual coinsurance maximum for The Excelsior Plan.
[5] Certain preventive adult immunizations are paid-in-full benefits. Select vaccines are paid-in-full benefits 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 SM AN EMPIRE PLAN OPTION	
Medical/Surgical Benefits	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
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 and Physical Therapy	$20 copayment per visit $20 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 $30 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	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	**Network Providers/Facilities**	**Non-Network**	**Network Providers/Facilities**	**Non-Network**
Covered Inpatient Services (Precertification is required)	No copayment	Not subject to deductible. 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		No copayment	
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 $20 copayment.	After the combined annual deductible is met, the Plan pays 80 percent of reasonable and customary charges for covered services.[3] After the combined coinsurance maximum is reached, the Plan pays 100 percent of reasonable and customary amount for covered services.[2]	Up to three visits per crisis are paid in full for mental health treatment; additional visits are subject to a $30 copayment.	Basic Medical Program: After the combined annual deductible is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined coinsurance maximum is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]
Emergency Department Visit	$70 copayment (waived if admitted)	Network coverage applies	$100 copayment (if admitted, only inpatient copayment applies)	Network coverage applies
Emergency Ambulance Service	No copayment		$35 copayment	
Annual Out-of-Pocket Costs[6]				
Deductible	$1,000 per enrollee, $1,000 per enrolled spouse/domestic partner, $1,000 per all dependent children combined		$1,250 per enrollee, $1,250 per enrolled spouse/domestic partner, $1,250 per all dependent children combined	
Coinsurance Maximum	$3,000 per enrollee, $3,000 per enrolled spouse/domestic partner, $3,000 per all dependent children combined		$4,000 per enrollee, $4,000 per enrolled spouse/domestic partner, $4,000 per all dependent children combined	
Prescription Drug Program[5,7,8,9]				
	Empire Plan		**Excelsior Plan**	
	Mail Order Pharmacy	**Network Pharmacy**	**Mail Order Pharmacy**	**Network Pharmacy**
Level 1	(most generics)		(most generics)	
Up to 30 Days	$5	$5	$10	$10
31-90 Days	$5	$10	$20	$25
Level 2	(Preferred Drugs)		(Preferred Drugs)	
Up to 30 Days	$25	$25	$40	$40
31-90 Days	$50	$50	$95	$95
Level 3	(all other covered drugs)		(all other covered drugs)	
Up to 30 Days	$45	$45	$70	$70
31-90 Days	$90	$90	$180	$180

[5] Certain preventive adult immunizations are paid-in-full benefits. Select vaccines are paid-in-full benefits when administered by a licensed pharmacist in a network pharmacy as well as when administered by a network physician during an office visit.
[6] The Out-of-Pocket Limit for in-network expenses incurred under the Hospital Program, Medical/Surgical Program and Mental Health and Substance Abuse Program is $4,300 for Individual coverage and $8,600 for Family coverage for both the Empire and Excelsior Plans.
[7] The Out-of-Pocket Limit for in-network expenses incurred under the Prescription Drug Program is $2,300 for Individual coverage and $4,600 for Family coverage for both the Empire and Excelsior Plans. This does not apply to Medicare-primary Empire Plan enrollees and their dependents.
[8] Empire Plan: If the enrollee's doctor believes a brand-name drug is medically necessary, the enrollee may appeal mandatory generic substitution. If approved, Level 3 copayment applies and ancillary fee is waived. Quantity level limits exist for erectile dysfunction and migraine medications.
[9] Excelsior Plan: No generic appeal, Level 3 copayment and applicable ancillary fee is charged. Quantity level limits are included in most therapeutic categories.