At A GLANCE

JANUARY 2025

SEHP • Student Employee Health Plan

For Graduate Student Employees and for their enrolled Dependents; and for COBRA Enrollees and Young Adult Option Enrollees with SEHP benefits

This guide briefly describes the principal New York State Health Insurance Program (NYSHIP) SEHP benefits. It is not a complete description and is subject to change.

If you have questions about eligibility, enrollment procedures or the cost of health insurance, contact the Health Benefits Administrator (HBA) on your SUNY campus. CUNY SEHP enrollees with questions may contact their HBA at the CUNY University Benefits Office. If you have questions regarding specific benefits or claims, contact the appropriate Empire Plan administrator (see page 23).

NEW YORK STATE | Department of Civil Service
Student Employee Health Plan

New York State Department of Civil Service Employee Benefits Division
Albany, NY 12239 | www.cs.ny.gov/employee-benefits

WHAT'S NEW

- **In-Network Out-of-Pocket Limit** – Each year the federal Patient Protection and Affordable Care Act sets new amounts limiting total network out-of-pocket costs. For 2025, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan is $9,200 for Individual coverage and $18,400 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Use and Prescription Drug Programs. See page 4 for more information.
- **2025 Empire Plan Flexible Formulary Drug List** – The annual update lists the most commonly prescribed generic and brand-name drugs included in the 2025 Empire Plan Flexible Formulary and newly excluded drugs with alternatives.
- **Insulin Coverage** – Effective January 1, 2025, covered prescription insulin drugs will not be subject to a deductible, copayment, coinsurance or any other cost-sharing requirement.
- **Annual Mammogram Screening Coverage** – The Plan covers annual mammogram screenings at no cost when an enrollee uses a network facility or provider. New York State mandates annual mammogram screening coverage even though the federal recommendation is only once every two years for most patients.
- **Dental Plan Administrator Changed to Anthem Blue Cross** – Effective October 1, 2024, the New York State Dental Plan administrator changed from EmblemHealth to Anthem Blue Cross. There is no impact or change to dental benefits as a result of this transition. Enrollees and covered dependents have access to an expanded network of dental providers offering the highest quality of care.

Quick Reference

The NYSHIP Student Employee Health Plan is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan has six main parts:

Hospital Program

administered by Anthem Blue Cross

Provides coverage for inpatient and outpatient services provided by a hospital or birthing center and for hospice care. Also provides inpatient Benefits Management Program services for preadmission certification of scheduled hospital admissions or within 48 hours after an emergency or urgent admission.

Medical/Surgical Program

administered by UnitedHealthcare

Provides coverage for medical services, such as office visits, surgery, diagnostic testing, urgent care and convenience care clinic visits under the network and non-network programs. Coverage for chiropractic care and physical therapy is provided through the Managed Physical Medicine Program. Home care services provided in lieu of hospitalization and diabetic supplies are provided by the Home Care Advocacy Program. Benefits Management Program services for Prospective Procedure Review for MRIs, MRAs, CT scans, PET scans and nuclear medicine tests.

Mental Health and Substance Use Program

administered by Carelon Behavioral Health

Provides coverage for inpatient and outpatient mental health and substance use care services. Also provides precertification of inpatient and certain outpatient services, concurrent reviews, case management and discharge planning.

Prescription Drug Program

administered by CVS Caremark

Provides coverage for prescription drugs dispensed through Empire Plan network pharmacies, the CVS Mail Service Pharmacy, the CVS Specialty Pharmacy and non-network pharmacies.

Dental Program

administered by Anthem Blue Cross 1-833-821-1949

Provides coverage for dental examinations, cleanings, fillings and bitewing X-rays. Also provides discounts on other services.

Vision Program

administered by Davis Vision 1-888-588-4823

Provides coverage for routine eye examinations, eyeglasses or contact lenses.

See *Contact Information* on page 23.

2025 Copayments at a Glance†

Medical/Surgical Program	**Participating Provider Program*** $10 copayment – Office visit, telehealth visit, office surgery, urgent care center visit, convenience care clinic visit, infertility treatment visit, allergy testing $10 copayment – Diagnostic laboratory tests, radiology (not performed during an office visit) $15 copayment – Licensed ambulance service **Chiropractic treatment or physical therapy services (Managed Physical Medicine Program)** $10 copayment – Office visit, up to 15 chiropractic visits per person per calendar year; up to 60 physical therapy visits per diagnosis $10 copayment – Diagnostic laboratory tests or radiology
Hospital Program	$15 copayment – Surgery, hospital-owned urgent care center visit, diagnostic radiology, diagnostic laboratory tests and bone mineral density screening in the hospital outpatient department of a network hospital or an extension clinic (including outpatient surgical locations) $25 copayment – Emergency department care $200 copayment – Per admission for covered inpatient hospital stays $10 copayment – Per visit for medically necessary physical therapy (following related hospitalization or surgery); up to 60 visits
Mental Health and Substance Use Program	$10 copayment – Office visit or telehealth visit to network practitioner* $25 copayment – Emergency department care $200 copayment – Per admission for a covered inpatient mental health or substance use detoxification stay
Prescription Drug Program	**Up to a 30-day supply from a participating retail pharmacy, mail service or designated specialty pharmacy:** $5 copayment – Level 1 or generic drug $25 copayment – Level 2 or preferred brand-name drug $45 copayment – Level 3 or non-preferred brand-name drug **31- to 90-day supply through the mail service or designated specialty pharmacy:** $5 copayment – Level 1 or generic drug $50 copayment – Level 2 or preferred brand-name drug $90 copayment – Level 3 or non-preferred brand-name drug Certain covered drugs do not require a copayment (see page 17).
Dental Program	$20 copayment – Participating provider visit, up to two examinations and two cleanings per person per calendar year $10 copayment – Filling, up to two fillings per person per calendar year
Vision Program	$10 copayment – Routine eye exam

† *Preventive care services under the Patient Protection and Affordable Care Act, women's health care services and certain other covered services are not subject to copayment.*

* *Office visits to a network practitioner are subject to a 15-visit annual limit per covered individual. For visit 16 and beyond, non-network coverage applies. Certain covered services are not subject to the 15-visit per person limit.*

Benefits Management Program

The Empire Plan Benefits Management Program helps to protect the enrollee and allows the Plan to continue to cover essential treatment for patients by coordinating care and avoiding unnecessary services. The Benefits Management Program precertifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient medical case management. In order to receive maximum benefits under the Plan, you must follow the Benefits Management Program requirements. This includes obtaining precertification for certain services when the Student Employee Health Plan is your primary coverage (pays first, before another health plan or Medicare).

You must call the Plan and choose the Hospital Program (see *Contact Information*, page 23) for preadmission certification:

- Before a scheduled (nonemergency) hospital admission.*
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.*
- For admission resulting from complications due to pregnancy or for any reason other than the delivery of the baby.* It is also recommended that you call if you or your baby are hospitalized for more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery.

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

** These services are subject to a $200 penalty if the hospitalization is determined to be medically necessary, but not precertified.*

Other Benefits Management Program services provided by the Hospital Program include:

- Concurrent review of hospital inpatient treatment
- Discharge planning for medically necessary services post-hospitalization
- Inpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care
- The Building Healthy Families Program for access to pre-pregnancy, maternity and postpartum care and parenting support

You must call the Plan and choose the Medical/Surgical Program (see *Contact Information*, page 23) for Prospective Procedure Review before receiving the following scheduled (nonemergency) diagnostic tests:

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

Precertification is required unless you are having the test as an inpatient in a hospital. Your costs will be higher if you do not call before receiving nonemergency diagnostic testing. If you do not call and the test or procedure is determined to be medically necessary by the Program Administrator, you will pay up to $250 in costs. If the test or procedure is determined not to be medically necessary, you will be responsible for the entire cost.

Other Benefits Management Program services provided by the Medical/Surgical Program include:

- Coordination of voluntary specialist consultant evaluation
- Outpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care

Out-of-Pocket Costs

In-Network Out-of-Pocket Limit

As a result of the federal Patient Protection and Affordable Care Act provisions, there is a limit on the amount you will pay out of pocket for in-network services/supplies received during the plan year.

Out-of-Pocket Limit: The amount you pay for network services/supplies is capped at the out-of-pocket limit. Network expenses include copayments you make to providers, facilities and pharmacies (network expenses do not include premiums, deductibles or coinsurance). Once the out-of-pocket limit is reached, network benefits are paid in full.

Beginning January 1, 2025, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,950 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $3,250 for in-network expenses incurred under the Prescription Drug Program

Family Coverage

- $11,900 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $6,500 for in-network expenses incurred under the Prescription Drug Program

Out-of-Network Combined Annual Deductible

The combined annual deductible is $100 per covered individual.

The combined annual deductible must be met before Basic Medical Program expenses, non-network expenses under the Home Care Advocacy Program and non-network, outpatient expenses under the Mental Health and Substance Use Program will be considered for reimbursement.

Preventive Care Services

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

When your participating provider recommends preventive care services for you that meet PPACA federally established criteria (such as age, gender and risk factors), those preventive services are provided to you at no cost when you use an Empire Plan participating provider or network facility. See the *2025 Empire Plan Preventive Care Coverage Guide* for a list of covered services.

For further information, visit www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html.

Hospital Program

PRESS OR SAY 2 Call the Plan and press or say 2 to reach the Hospital Program (see *Contact Information*, page 23)

The Hospital Program provides benefits for services provided in a network or non-network inpatient or outpatient hospital setting or hospice setting. Services must be covered and medically necessary. The Medical/Surgical Program provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by the Hospital Program.

Call the Hospital Program for preadmission certification or if you have questions about your benefits, coverage or an Explanation of Benefits statement.

Network coverage applies when you receive emergency or urgent services in a non-network hospital, or when you use a non-network hospital because you do not have access to a network hospital. Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Network Coverage

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

Non-Network Coverage

When you use a hospital that is not part of The Empire Plan network, your out-of-pocket costs are higher. After you pay your deductible amount, the Plan pays 80 percent of the allowable amount. You are responsible for the balance.

Allowable amount means the amount you actually paid for covered, medically necessary services or the network allowance as determined by Anthem Blue Cross.

Hospital Inpatient

You must call for preadmission certification (see page 3)

The Hospital Program provides unlimited days of care for covered medical or surgical care in a hospital, including inpatient detoxification. An additional copayment is required if the hospitalization occurs more than 90 days after a previous discharge for the same illness or injury.

Network Coverage

$200 copayment per person per admission. The Plan pays 100 percent of the allowable amount after you pay the copayment.

Maternity care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section, or first 96 hours following a cesarean section, are presumed medically necessary and covered at the same copayment and coverage level as other inpatient admissions. You are required to call if you are admitted to the hospital during your pregnancy due to complications or for any reason other than the delivery of the baby. If you choose early discharge following delivery, you may request one paid-in-full home care visit.

Non-Network Coverage

$200 copayment per person per admission. The Plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Maternity care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section, or first 96 hours following a cesarean section, are presumed medically necessary. You are required to call if you are admitted to the hospital during your pregnancy due to complications or for any reason other than the delivery of the baby. The plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Hospital Outpatient

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

Emergency Department

Network Coverage

You pay one $25 copayment per visit to an emergency department, including use of the facility for emergency care, services of the attending emergency department physician, services of providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services.

Non-Network Coverage

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

Emergency is defined as a medical condition with symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate care to put the person's life in jeopardy or cause serious impairment of bodily functions.

Outpatient Department

Services covered in a network hospital outpatient department or extension clinic are the same services covered when received in a non-network facility.

Network Coverage

You pay one $15 copayment per visit for outpatient surgery, diagnostic radiology, diagnostic laboratory tests and bone mineral density screening.

You pay one $15 copayment per visit to a hospital outpatient urgent care facility.

The following services are paid in full when designated preventive according to the Patient Protection and Affordable Care Act:

- Bone mineral density tests
- Colonoscopies
- Lung cancer screenings
- Mammograms*
- Pap smears
- Proctosigmoidoscopy screenings
- Prostate cancer screenings
- Sigmoidoscopy screenings

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

Non-Network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible (per covered individual).

Physical therapy following a related hospitalization or related inpatient or outpatient surgery is subject to a $10 copayment per visit. Up to 60 medically necessary visits are covered under network coverage.

Physical therapy covered under the non-network benefit is subject to a separate combined $100 deductible for physical therapy and chiropractic care (see page 13).

Medically necessary physical therapy is covered under the Managed Physical Medicine Program when not covered under the Hospital Program (see page 13).

Infertility

Network Coverage

The following services provided in the inpatient or outpatient departments of a hospital are covered: artificial/intrauterine insemination; three in vitro fertilization (IVF) cycles per lifetime; fertility preservation when a medical treatment will directly or indirectly lead to infertility; inpatient and/or outpatient surgical or medical procedures performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility and associated diagnostic tests and procedures including, but not limited to, those described in New York State Insurance Law as set forth in Chapter 82 of the Laws of 2002.

Non-Network Coverage

Outpatient infertility treatment: The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Inpatient infertility treatment: The Plan pays 80 percent of the allowable amount after you pay the $200 copayment.

Hospice Care

Network Coverage

Care provided by a licensed hospice program is paid in full for up to 210 days. Enrollees are eligible for hospice care if the doctor and hospice medical director certify that the covered patient is terminally ill and likely has less than 12 months to live.

Non-Network Coverage

The Plan pays up to 100 percent of allowable amount for up to 210 days for care provided by a licensed hospice program.

Medical/Surgical Program

PRESS OR SAY 1 Call the Plan and press or say 1 to reach the Medical/Surgical Program (see *Contact Information*, page 23)

The Medical/Surgical Program provides benefits for medically necessary, covered services received from a physician or other practitioner licensed to provide medical/surgical services. It also covers services received from facilities not covered under the Hospital Program, such as outpatient surgical centers, imaging centers, laboratories, urgent care centers and convenience care clinics. Call the Medical/Surgical Program if you have questions about the status of a provider, Plan coverage or your benefits.

Network Coverage

Network coverage applies when you use a physician or provider who participates in The Empire Plan network.

When you receive covered services from a participating provider, you pay only applicable copayments. Women's health care services, many preventive care services and certain other covered services are paid in full (see pages 8–12).

To learn whether a provider participates, check with the provider directly, call the Medical/Surgical Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, and select Find an Empire Plan Provider. Always confirm the provider's participation before you receive services.

15-visit Per Person Limit

Most types of visits to a network provider are subject to a 15-visit per person annual limit. Non-network coverage applies after you reach the annual limit.

Preventive care visits are not subject to the 15-visit per person limit.

Note: Any visit you make to your SUNY Campus Student Health Center (which is not a network provider) does not count toward the 15-visit per person limit. (This does not apply to CUNY SEHP enrollees.)

Non-Network Coverage

Non-network coverage applies when you use a physician or provider that is not in The Empire Plan network, and when you exceed the 15-visit limit in a network setting, for those services that are subject to the limit. Your out-of-pocket costs are higher when you use non-network coverage.

Once you meet the combined $100 annual deductible per covered individual (see page 4), the Plan pays 80 percent of the allowable amount for covered services.

Allowable amount means the amount you actually paid for covered, medically necessary services, or the network allowance as determined by UnitedHealthcare, whichever is lower. The network allowance generally equates to 20 percent of FAIR Health® Usual and Customary professional rates.* FAIR Health® is a nonprofit organization approved by the State of New York as a benchmarking database. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the usual and customary rate for these services in your geographic area or ZIP code.

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health® rates.*

Office Visit/Office Surgery and Laboratory/Radiology

Network Coverage

You have network coverage for up to 15 visits per person per calendar year for office visits, including office surgery, provided by a network provider, subject to a $10 copayment per visit. The copayment includes diagnostic laboratory tests and radiology performed during the office visit.

Certain visits and laboratory/radiology services are paid in full and do not count toward the 15-visit per person annual limit, including well-child care; prenatal and postnatal office visits included in your provider's delivery charge; visits for preventive care; women's health care, including certain contraceptives provided in a physician's office; dialysis; chemotherapy; and radiation therapy.

Visits to a participating urgent care center that is not affiliated with a hospital are subject to a $10 copayment but do not count toward the 15-visit per person annual limit for network benefits.

Diagnostic laboratory tests and radiology not performed during an office visit are covered, subject to a separate $10 copayment, but do not count toward the 15-visit per person annual limit for network benefits.

Outpatient surgery physician charges are not subject to copayment and do not count toward the 15-visit per person annual limit for network benefits.

Non-Network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Network Coverage	Non-Network Coverage
Mammogram screening: The following services are paid in full and do not count toward the 15-visit per person annual limit for network benefits. Screening, diagnostic and 3-D mammograms are paid in full under New York State law.	**Mammogram screening:** The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.
Infertility treatment: $10 copayment for covered services such as artificial/intrauterine insemination (see *Infertility*, page 7) provided during an office visit. Coverage provided for a maximum of three cycles of in vitro fertilization (IVF).	**Infertility treatment:** The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible (covered services only, see page 7).

To verify coverage of benefits for IVF and to find a network provider, call the Medical/Surgical Program.

Second surgical opinion: $10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; subject to the 15-visit per person annual limit. One paid-in-full in-hospital consultation in each field per confinement.	**Second surgical opinion:** Same limits apply as under network coverage. The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible.
Second opinion for cancer diagnosis: $10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer, recurrence of cancer or a recommended course of treatment for cancer.	**Second opinion for cancer diagnosis:** Covered services are the same as under network coverage.

Routine Health Exams

Network Coverage	Non-Network Coverage
Preventive annual routine health exams are paid in full and are not subject to the 15-visit per person annual limit. Other covered non-preventive services received during a routine health exam may be subject to copayment(s).	Routine physicals are covered once every two years for the active employee under age 40, or annually for the active employee over age 40. The Plan pays 80 percent of the allowable amount for covered services. This benefit is not subject to copayment, deductible or the 15-visit per person annual limit. Covered services, such as laboratory tests and screenings provided during the office visit for a routine exam that fall outside the scope of a routine exam, are subject to deductible and coinsurance. There is no coverage for routine health exams for a spouse or domestic partner. For further information contact the Medical/Surgical Program.

Routine Well-Child Care

Network Coverage

Paid-in-full benefit for children up to age 19, including examinations and immunizations administered pursuant to pediatric guidelines. Well-child care visits do not count toward the 15-visit per person annual limit for network benefits.

Non-Network Coverage

The Plan pays 100 percent of the allowable amount. This benefit is not subject to deductible or coinsurance.

Enteral Formulas and Modified Solid Food Products

Non-Network Coverage

For prescribed enteral formulas, the Plan pays up to 80 percent of the allowable amount after you meet the combined annual deductible. For certain prescribed modified solid food products, the Plan pays up to 80 percent of the allowable amount after you meet the combined annual deductible.

Ambulatory Surgical Center

Network Coverage

$10 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a surgical center.

Non-Network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Adult Immunizations

Network Coverage

The following adult immunizations are covered at no cost to you, based on recommendations by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC):*

- COVID-19
- Hepatitis A
- Hepatitis B
- Herpes zoster (shingles)
  - Shingrix®

    No copayment is required for enrollees and dependents age 19 and older. A prescription may be required for enrollees age 19–49.
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, rubella
- Meningococcal (meningitis)
- Mpox
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Tetanus, diphtheria, pertussis
- Varicella (chickenpox)

Doses, recommended ages and populations vary. Other immunizations may be subject to a copayment.

** Paid in full under the Prescription Drug Program at all CVS Caremark National Vaccine Network Pharmacies subject to age limitations and CDC guidelines. See page 19 for vaccinations covered under the Prescription Drug Program.*

Non-Network Coverage

Not covered.

Allergy Care

Network Coverage

Office visits are covered, subject to a $10 copayment and the 15-visit per person annual limit. Basic skin tests done during an office visit are not subject to a separate copayment. Tests provided on a different date or at a different location require a separate $10 copayment, but do not count toward the 15-visit per person limit. Allergy injections and extracts are not covered (see *Exclusions*, page 22).

Non-Network Coverage

Not covered.

Pregnancy Termination

Network Coverage

Paid-in-full benefit; does not count toward 15-visit per person annual limit.

Non-Network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 annual deductible.

Gender Affirmation Treatment

Network and Non-Network Coverage

Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery and other associated surgeries, services and procedures, including those to change your physical appearance to more closely conform secondary sex characteristics to those of your identified gender, are covered when your behavioral health provider completes a determination of medical necessity and confirms that you have a diagnosis of gender dysphoria, have the capacity to make a fully-informed decision and consent for treatment and are 18 years of age or older.

Ambulance Service

Network Coverage

You pay a $15 copayment for local commercial emergency ambulance service.

Emergency Ambulance Transportation is covered when the service is provided by a licensed ambulance service to the nearest hospital where emergency care can be performed and ambulance transportation is required because of an emergency condition.

Inpatient in a Hospital or Birthing Center

Network Coverage

Covered services received from a network provider while you are an inpatient are paid in full and do not count toward the 15-visit per person limit.

Paid-in-full benefit for preadmission and/or presurgical testing for radiology, anesthesiology and pathology.

Non-Network Coverage

The Plan pays 80 percent of the allowable amount for covered services after you meet the combined $100 deductible.

Outpatient Department of a Hospital

Network Coverage

Paid-in-full benefit for covered outpatient services provided in the outpatient department of a hospital by a network provider.

Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, chemotherapy, anesthesiology, radiology, pathology or dialysis when not covered by Anthem Blue Cross; does not count toward the 15-visit per person limit.

Non-Network Coverage

For covered services by a non-network provider, the Plan pays 80 percent of the allowable amount for covered services after you meet the combined $100 deductible.

The Plan pays up to 100 percent of the allowable amount.

Medical/Surgical Program Benefits for Physician/Provider Services Received in a Hospital Inpatient or Outpatient Setting

When you receive covered services from a physician or other provider in a hospital, and those services are billed by the provider (not the facility), the following Medical/Surgical Program benefits apply:

Participating Provider Program
Covered services are paid with no cost to you when the provider participates in The Empire Plan network.

Non-Network Coverage
If you receive services in connection with covered inpatient or outpatient services at an Empire Plan network hospital and the Plan provides your primary coverage, covered charges billed separately for anesthesiology, pathology, radiology and neonatology; care provided by assistant surgeons, hospitalists and intensivists; and diagnostic services (including radiology and laboratory services) will be paid with no cost to you by the Medical/Surgical Program. Services provided by other nonparticipating providers are subject to deductible and coinsurance.

Emergency care in a hospital emergency department and inpatient services resulting from an emergency admission are covered as follows:

- An attending emergency department physician is paid with no cost to you
- Participating and nonparticipating providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams and/or pathology are paid with no cost to you
- Other participating providers are paid with no cost to you
- Other nonparticipating providers (e.g., surgeons) are paid with no cost to you

The Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from nonparticipating (non-network) providers at a network facility without their knowledge. See *Out-of-Network Reimbursement Disclosures* or contact the Medical/Surgical Program for more information.

Managed Physical Medicine Program

Administered by Managed Physical Network (MPN)

Chiropractic Treatment and Physical Therapy

Network Coverage

Each office visit to a network provider is subject to a $10 copayment. Related radiology and diagnostic laboratory services billed by the network provider are subject to a separate $10 copayment. No more than two copayments per visit will be assessed.

MPN guarantees access to network benefits. If there are no network providers in your area, you must contact MPN prior to receiving services to arrange for network benefits. Physical therapy must be prescribed by a provider.

Chiropractic treatment: Up to 15 visits per person per calendar year.

Physical therapy: Up to 60 visits per diagnosis, if determined to be medically necessary.

Non-Network Coverage

Non-network benefits apply for covered services received from non-network providers, or after the 15th in-network chiropractic visit per year, or after the 60th in-network physical therapy visit per diagnosis.

Annual deductible: Subject to a separate combined $100 deductible per covered individual for physical therapy and chiropractic treatment, including hospital-based physical therapy. This deductible is separate from the combined annual deductible.

Coinsurance: The Plan pays up to 80 percent of the allowable amount after you meet the annual deductible.

Allowable amount means the amount you actually paid for covered, medically necessary services, or the network allowance as determined by UnitedHealthcare, whichever is lower. The network allowance generally equates to 13 percent of FAIR Health® Usual and Customary professional rates.*

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health® rates.*

Home Care Advocacy Program (HCAP)

Diabetic Equipment/Supplies, Home Care Services and Durable Medical Equipment and Supplies Provided in Lieu of Hospitalization

You must call
for prior authorization

Network Coverage *(when you use HCAP)*	Non-Network Coverage *(when you don't use HCAP)*
Diabetic equipment and supplies, including insulin pumps, are paid in full. To receive diabetic equipment and supplies, call The Empire Plan Diabetic Supplies Pharmacy at 1-800-321-0591. Certain diabetic supplies are covered in full when purchased at a network pharmacy. For insulin pumps, you must use a network provider. Call the Medical/Surgical Program and choose HCAP for prior authorization.	Diabetic equipment and supplies are covered up to 100 percent of the allowable amount; not subject to deductible or coinsurance. The HCAP network allowance generally equates to 32 percent of FAIR Health® Usual and Customary professional rates.*
Home care services provided in lieu of hospitalization are paid in full for 365 visits. To receive this benefit, you must call the Medical/Surgical Program and choose HCAP for prior authorization.	Home care services are not covered unless precertified. If precertified, the Plan pays 80 percent of allowable amount after you meet the combined annual deductible.
Durable medical equipment and supplies (other than diabetic equipment or supplies) are covered in lieu of hospitalization when precertified. To receive this benefit, you must call the Medical/Surgical Program and choose HCAP for prior authorization.	Not covered.

Allowable amount means the amount you actually paid for covered, medically necessary services, or the network allowance as determined by UnitedHealthcare, whichever is lower.

Important: If Medicare is your primary coverage and you do not use a Medicare contract provider, your benefits will be reduced. If you are in an area that participates in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, you must use a Medicare-approved supplier. To locate a Medicare contract supplier, visit www.medicare.gov/medical-equipment-supplies/ or contact The Empire Plan.

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health® rates.*

Mental Health and Substance Use Program

PRESS OR SAY 3 **For the highest level of benefits, call the Plan and press or say 3 to reach the Mental Health and Substance Use Program (see *Contact Information*, page 23)**

To receive the highest level of benefits you must call the Mental Health and Substance Use (MHSU) Program before seeking services from a mental health or substance use care provider. This includes services that require precertification to confirm medical necessity before starting treatment (see list below). Call The Empire Plan and press or say 3 to reach the Mental Health and Substance Use Program. You can reach the Clinical Referral Line by selecting option 3 from the MHSU Program menu. The Clinical Referral Line is available 24 hours a day, every day of the year. In an emergency, go to the nearest hospital emergency department. You or your designee should call the Mental Health and Substance Use Program within 48 hours of an admission for emergency care or as soon as reasonably possible.

To check if providers or facilities are in The Empire Plan network, visit the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, and select Find an Empire Plan Provider. Under the MHSU Program, click on the ReferralConnect link. On ReferralConnect you can search for a specific provider or provider type in your area. If there are no network providers in your area, you have guaranteed access to network level benefits if you call the Clinical Referral Line to arrange your care with an appropriate provider.

Schedule of Benefits for Covered Services

The Program Administrator must certify all covered services as medically necessary, regardless of whether you are using network or non-network coverage. If the Program Administrator does not certify your inpatient or outpatient treatment as medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

The following services require Precertification from the Program Administrator:

- Intensive outpatient program for mental health
- Structured outpatient program for substance use disorder*
- 23-hour bed for mental health or substance use disorder
- 72-hour bed for mental health or substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavioral Analysis (ABA)
- Group home
- Halfway house
- Residential treatment center for mental health**
- Residential treatment center for substance use disorder*
- Partial hospitalization for mental health
- Partial hospitalization for substance use disorder*

** Precertification is not required for OASAS-certified Network Facilities located within New York State.*

*** Precertification is not required for covered individuals under 18 years of age at OMH-certified Network Facilities located within New York State.*

Network Coverage

Network coverage applies when you use a physician, provider or facility that participates in The Empire Plan network. When you use a network provider or facility, you pay applicable copayments for covered services. Always confirm the provider's participation before you receive services.

15-visit Per Person Limit
Most types of visits to a network provider are subject to a 15-visit per person annual limit. Non-network coverage applies after you reach the annual limit.

Non-Network Coverage

Non-network coverage applies when you use a physician, provider or facility that is not in The Empire Plan network, and when you exceed the 15-visit limit in a network setting for those services that are subject to the limit. Your out-of-pocket costs are higher when you use non-network coverage.

Allowable amount means the lowest of the actual charge, the provider's usual charge or the usual charge within the same geographic area. The Plan generally utilizes FAIR Health® rates at the 90th percentile to determine the allowable amount. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the UCR for these services in your geographic area.

Inpatient Services

You should call before an admission to a mental health or substance use care facility to ensure that benefits are available. In the case of an emergency admission, certification should be requested as soon as possible. Network facilities are responsible for obtaining precertification. If you use a non-network facility, you may be required to pay the full cost of any stay determined not to be medically necessary.

A new copayment is required if admission occurs more than 90 days after the previous admission.

Approved General Acute Hospital, Psychiatric Hospital or Clinic

The following mental health or substance use treatment is covered in an approved general acute hospital, psychiatric hospital or clinic:

- Inpatient hospitalization
- Partial hospitalization
- Intensive outpatient
- Day treatment programs
- 23-hour extended crisis beds
- 72-hour crisis beds
- Residential treatment centers
- Approved group home
- Halfway house

A new copayment is required if admission occurs more than 90 days after the previous admission.

Network Coverage

$200 copayment per person per admission. The Plan pays 100 percent of the allowable amount after you pay the copayment.

Non-Network Coverage

$200 copayment per person per admission. The Plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Outpatient Services

Hospital Emergency Department

Network Coverage

You pay a $25 copayment per visit to an emergency department. If you are admitted as an inpatient directly from the outpatient department or emergency department, only the inpatient copayment applies (see page 12).

Non-Network Coverage

Network coverage applies to emergency department visits at a non-network hospital.

Office Visits and Other Outpatient Services

Network Coverage

Office visits and other outpatient services, such as outpatient substance use rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a $10 copayment and a 15-visit per person annual limit for network benefits. For visit 16 and beyond, non-network coverage applies.

Non-Network Coverage

Non-network benefits apply for covered services received from non-network practitioners or after the 15th visit to a network practitioner. Services are subject to the combined $100 annual deductible per covered individual. The Plan pays 80 percent of the allowable amount for covered services after you pay the deductible.

Prescription Drug Program

PRESS OR SAY 4 Call the Plan and press or say 4 to reach the Prescription Drug Program (see *Contact Information*, page 23)

Copayments

You have the following copayments for drugs purchased from a participating pharmacy, the mail service pharmacy or the designated specialty pharmacy. You have coverage for prescriptions for more than a 30-day supply through the mail service pharmacy or designated specialty pharmacy.

Drug Category	Up to a 30-day Supply from a Participating Pharmacy, the Mail Service Pharmacy or the Designated Specialty Pharmacy	31- to 90-day Supply from the Mail Service Pharmacy or the Designated Specialty Pharmacy
Level 1 Drugs or for Most **Generic** Drugs	$5	$5
Level 2 Drugs, **Preferred** Drugs or Compound Drugs	$25	$50
Level 3 Drugs or **Non-Preferred** Drugs	$45	$90

Note: At certain SUNY Campus Student Health Centers, SUNY SEHP enrollees and/or their enrolled dependents are able to fill prescriptions for a $7 copayment for up to a 30-day supply. See your Health Benefits Administrator for more information. (This does not apply to CUNY SEHP enrollees.)

Drugs Not Subject to Copayment

Certain covered drugs do not require a copayment when using a network pharmacy:

- Oral chemotherapy drugs, when prescribed for the treatment of cancer
- Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices), with up to a 12-month supply of contraceptives at one time without an initial 3-month supply
- Medications used for emergency contraception and pregnancy termination
- Tamoxifen, raloxifene (for patients age 35 and over), anastrozole and exemestane, when prescribed for the primary prevention of breast cancer
- Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), when prescribed for enrollees who are at high risk of acquiring HIV
- Certain preventive adult vaccines when administered by a licensed pharmacist at a pharmacy that participates in the CVS Caremark national vaccine network
- Certain prescription and over-the-counter medications* that are recommended for preventive services without cost sharing and have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF)

** When available over-the-counter, USPSTF “A” and “B” rated medications require a prescription order to process without cost sharing.*

Brand-Name Drugs with Generic Equivalent

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the non-preferred drug copayment plus the ancillary charge, not to exceed the full retail cost of the covered drug.

Ancillary Charge: The difference in cost between the brand-name drug and the generic equivalent.

Exceptions

- If the brand-name drug has been placed on Level 1 of The Empire Plan Flexible Formulary, you will pay the Level 1 copayment.
- You pay only the applicable copayment for the following brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. One copayment covers up to a 90-day supply. Most of these drugs will have non-preferred copayments with no ancillary fee charged.

Flexible Formulary Drug List

The Student Employee Health Plan uses The Empire Plan Flexible Formulary for prescription drugs. The Empire Plan Flexible Formulary drug list is designed to provide enrollees and the Plan with the best value in prescription drug spending. This is accomplished by:

- Excluding coverage for certain brand-name or generic drugs if the drug has no clinical advantage over other covered medications in the same therapeutic class.
- Placing a brand-name drug on Level 1 or excluding or placing a generic drug on Level 3, subject to the appropriate copayment. These placements may be revised mid-year when such changes are advantageous to the Plan. Enrollees will be notified in advance of such changes.
- Applying the highest copayment to non-preferred drugs that provide no clinical advantage over two or more Level 1 drug alternatives in the same therapeutic class. This may result in no Level 2 brand-name drugs.
- Including utilization management tools to promote transparency and reduce costs, not limited to generic substitution, prior authorization and physician education.

For the most up-to-date version, please visit the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, select Using Your Benefits, then select Empire Plan Formulary Drug Lists and then 2025 Empire Plan Flexible Formulary.

Prior Authorization Drugs

You must have prior authorization for certain drugs, including generic equivalents, noted with "PA" on the Empire Plan Flexible Formulary.

Certain medications also require prior authorization based on age, gender or quantity limit specifications. Compound drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization. **The drugs that require prior authorization are subject to change quarterly as drugs are approved by the U.S. Food and Drug Administration (FDA), introduced into the market or approved for additional indications.** For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits. From the NYSHIP website homepage, select Using Your Benefits, Empire Plan Formulary Drug Lists and then Prior Authorization Drug List.

Excluded Drugs

Certain brand-name and generic drugs are excluded from The Empire Plan Flexible Formulary if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2025 Empire Plan Flexible Formulary identifies drugs that are excluded in 2025, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. For a complete list of Excluded Drugs, call the Prescription Drug Program or go to the NYSHIP website.

Medical Exception Program for Excluded Drugs

A Medical Exception Program is available for non-formulary drugs that are excluded from coverage.

To request a medical exception, you and your physician must first evaluate whether covered drugs on the Flexible Formulary are appropriate alternatives for your treatment. After an appropriate trial of formulary alternatives, your physician may submit a letter of medical necessity to CVS Caremark that details the formulary alternative trials and any other clinical documentation supporting medical necessity. The physician can fax the exception request to CVS Caremark at 1-888-487-9257.

If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment will apply for non-preferred brand-name drugs.

Note: Drugs that are only FDA-approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

Dispense as Written (DAW) Exception Request

When your doctor writes your prescription as DAW for a non-preferred brand-name drug that has a generic equivalent, you pay the non-preferred (Level 3) copayment plus the ancillary charge, not to exceed the full retail cost of the drug. If your prescription is not written DAW, in most cases, the generic equivalent is substituted for the brand-name drug and you pay the generic drug (Level 1) copayment.

If your doctor believes it is medically necessary for you to have a non-preferred brand-name drug (that has a generic equivalent), your doctor must submit a DAW Exception Request form (available at www.caremark.com) or call The Empire Plan to request an exception.

If your DAW Exception Request is granted and you fill your prescription for a non-preferred brand-name drug at a Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy, you pay only the non-preferred (Level 3) copayment. You will not have to pay the ancillary charge. If your DAW Exception Request is denied, you may appeal to CVS Caremark.

If your appeal is approved, the pharmacy will either reverse and reprocess the claim, or the pharmacy will work with CVS Caremark to allow a new claim to be processed with the approved exception so that the ancillary charge is not applied.

Types of Pharmacies

Network Pharmacy

A network pharmacy is a retail pharmacy that participates in the CVS Caremark network. When you visit a network pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail network pharmacy location that participates in the CVS Caremark network, call the Prescription Drug Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, and select Find an Empire Plan Provider.

CVS Caremark 2025 National Vaccine Network Pharmacy

Select preventive vaccines are covered without copayment when administered at a pharmacy that participates in the CVS Caremark national vaccine network. Vaccines available in a pharmacy are:

- COVID-19
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Herpes zoster (shingles)*
- Human papillomavirus (HPV)
- Inactivated poliovirus (polio)
- Influenza (flu)
- Measles, mumps, rubella
- Meningococcal (meningitis)
- Mpox
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Rotavirus
- Tetanus, diphtheria, pertussis
- Varicella (chickenpox)

Certain vaccines have age limitations and follow the recommendations by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Only certain pharmacies are part of the CVS Caremark national vaccine network. To find out if a pharmacy participates in the CVS Caremark national vaccine network, call the Prescription Drug Program or visit www.empireplanrxprogram.com and select CVS Caremark, then Find a Local Pharmacy. Be sure to select Vaccine network under Advanced Search. Call the pharmacy in advance to verify availability of the vaccine.

** Shingrix® is covered for individuals 19 and older at no copayment. A prescription may be required for enrollees age 19–49.*

Mail Service Pharmacy

You may request that your prescriber send your prescription to the CVS Caremark Mail Service Pharmacy. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone or online at www.empireplanrxprogram.com or download forms on the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, select Forms and then scroll down to the CVS Caremark Mail Service Order Form.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services, including:

- Refill reminder calls
- Expedited, scheduled delivery of your medications at no additional charge
- All necessary supplies, such as needles and syringes applicable to the medication at no additional cost
- Disease education
- Drug education
- Compliance management
- Side-effect management
- Safety management

Prior authorization is required for many specialty medications. To get started with the CVS Caremark Specialty Pharmacy, to request refills or to speak to a specialty-trained pharmacist or nurse, please call The Empire Plan Monday through Friday between 7:30 a.m. and 9 p.m., Eastern time. Choose the Prescription Drug Program and ask to speak with Specialty Customer Care. If your call is urgent, you may request an on-call pharmacist 24 hours a day, seven days a week.

The list of specialty medications included in the Specialty Pharmacy Program is available on the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, select Using Your Benefits, Empire Plan Formulary Drug Lists and then Specialty Pharmacy Drug List.

Non-Network Pharmacy

If you do not use a network pharmacy, or if you do not use your benefit card at a network pharmacy, you must submit a claim for reimbursement to: The Empire Plan Prescription Drug Program, c/o CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136.

In most cases, you will not be reimbursed the total amount you paid for the prescription.

- If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the Program would reimburse a network pharmacy for that prescription, less your copayment.
- If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the Program would reimburse a network pharmacy for filling the prescription with that drug's generic equivalent, less your copayment, unless the brand-name drug has been placed on Level 1 of The Empire Plan Flexible Formulary.

Dental Plan

The NYS SEHP Dental Plan (administered by Anthem Blue Cross) is comprised of two components: an insured component and a discount program component, where you will pay out-of-pocket for services at a discounted rate approved by a participating dentist.

SEHP Insured Coverage

Maximum of two examinations, two cleanings and two fillings* per calendar year, per covered individual. A $20 copayment will apply for each examination/cleaning and a $10 copayment for each tooth filling, only when you visit a participating provider in the Anthem Blue Cross XPO Dental Complete – NY State Dental Plan SEHP network. Please note, if an examination and cleaning occur during the same visit, just one $20 copayment will apply. A $20 copayment for each service will apply if an examination and cleaning are performed in separate visits.

Covered Services

- Initial examination, including charting
- Periodic examination
- Cleanings
- Bitewing X-rays
- Fillings*

** Two fillings per year at a copayment of $10 per filling. The copayment will be charged once for each tooth, regardless of the number of fillings required within a tooth.*

Participating Provider

To locate a SEHP Dental Plan participating provider, visit the Anthem Blue Cross website at anthembluecross.com/nys-dental. Please select New York State Dental Plan Student Employee Health Plan (SEHP) under Search for a Dental Provider. You will be directed to the XPO Dental Complete network where you can search for providers by address, doctor name or specialty type. For non-covered services, you can additionally filter network results or select the link for Dental Discount Card Program Providers to view providers who may charge you less than their normal fee. Your provider must be in the Anthem Blue Cross XPO Dental Complete – NY State Dental Plan SEHP network. You can also call Anthem Blue Cross's dedicated Customer Service Center to locate a participating provider.

Anthem Blue Cross Dental Discount Card Program

You will be enrolled in the Anthem Blue Cross Dental Discount Card Program for all non-covered services under the SEHP Dental Plan. Under the program, you will receive preapproved discounted rates for services that are not covered under your insurance plan. You are required to pay your participating Anthem Discount Card Program provider directly for all care you receive.

- When you see an Anthem Discount Card Program participating provider for services that are not covered under your plan, the participating provider charges you less than their normal fee.
- You will not be subject to precertification, eligibility verification or other procedures generally associated with traditional fee-for-service programs when you utilize the discounted program.

To locate a participating provider in the Anthem Blue Cross Dental Discount Card Program, call Anthem Blue Cross's dedicated Customer Service Center at 1-833-821-1949.

ID Card

You will receive a separate identification card from Anthem Blue Cross. Present this identification card before you receive services from a provider who participates in the Anthem Blue Cross XPO Dental Complete – NY State Dental Plan SEHP network.

Questions

For eligibility questions, contact the Health Benefits Administrator on your campus.

For Customer Service, contact Anthem Blue Cross's dedicated Customer Service Center at 1-833-821-1949 after you have enrolled. Please direct your correspondence to: New York State Dental Plan, P.O. Box 1482, Minneapolis, MN 55440. Please be sure to include your identification number on all correspondence.

Vision Program

Network Benefits

You are covered for a routine eye exam, subject to a $10 copayment, once in any 24-month period (based on your last date of service).

A limited selection of frames and lenses or daily wear, disposable or planned replacement contact lenses offered by a participating provider at the time and place of an eye exam will be paid in full. This benefit is available only once in any 24-month period. There is no coverage for services received from a nonparticipating provider.

To Receive Services from a Network Provider

- Contact the network provider and schedule an appointment.
- Identify yourself as covered under the SEHP Vision Care Program available through the New York State Vision Plan, which is administered by Davis Vision.
- Give the provider your name and date of birth or member ID number.

The provider will confirm your eligibility and obtain an authorization to provide services. At the time of your appointment, you are responsible for a $10 copayment for vision services.

To Confirm Eligibility or Locate a Network Provider

Contact Davis Vision, the plan administrator, at 1-888-588-4823 or go to the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group, if prompted, select Dental & Vision Benefits to access the Davis Vision website.

Exclusions

Services not covered under the Student Employee Health Plan include, but are not limited to, the following:

- Adult immunizations that are not preventive
- Allergy extracts and injections
- Cardiac rehabilitation
- Care that is not medically necessary
- Cosmetic surgery*
- Custodial care
- Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, unless approved for gender affirmation treatment
- Durable medical equipment and supplies unless provided in lieu of hospitalization and precertified under the Home Care Advocacy Program
- Experimental or investigative procedures
- Hearing aids
- Occupational therapy
- Orthotics
- Prosthetics (except breast prostheses, which are paid in full)
- Reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intrauterine insemination, in vitro fertilization (IVF) [three cycles per lifetime], fertility preservation when a medical treatment will directly or indirectly lead to infertility and other services for which coverage is mandated by New York State Insurance Law)
- Routine foot care
- Skilled nursing facility care including rehabilitation
- Speech therapy
- Temporomandibular joint (TMJ) treatment (except when caused by a medical condition)
- Weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity)

** With the exception of a diagnosis of gender dysphoria and a determination of medical necessity (see page 11).*

Contact Information

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

PRESS OR SAY 1	**Medical/Surgical Program: *Administered by UnitedHealthcare*** Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time. TTY: 1-888-697-9054 P.O. Box 1600, Kingston, NY 12402-1600 Claims submission fax: 845-336-7716 Online submission: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Anthem Blue Cross*** Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Representatives are available Monday through Friday, 8 a.m. to 5 p.m., Eastern time. TTY: 711 New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 Claims submission fax: 866-829-2395 Online form: www.anthembluecross.com/nys/resources-forms
PRESS OR SAY 3	**Mental Health and Substance Use Program: *Administered by Carelon Behavioral Health*** Representatives are available 24 hours a day, seven days a week. TTY: 711 P.O. Box 1850, Hicksville, NY 11802 Claims submission fax: 855-378-8309 Online form: www.carelonbh.com/empireplan/en/home
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS Caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 711 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590

Dental Program: *Administered by Anthem Blue Cross:* 1-833-821-1949

Vision Program: *Administered by Davis Vision:* 1-888-588-4823

Benefits on the Web

The NYSHIP website is a complete resource for your health insurance benefits, including:

- Current publications describing your benefits and plan
- Announcements
- Resources
- Prescription drug information
- Contact information
- Links to all Empire Plan program administrator websites

To find the most up-to-date information about your health insurance coverage, go to **www.cs.ny.gov/employee-benefits**. Choose your group, if prompted, to get to the NYSHIP website homepage.

This document provides a brief look at the Student Employee Health Plan (SEHP) medical, dental and vision care benefits. If you have any questions or need claims forms, call the appropriate benefits administrator.

NEW YORK STATE | **Department of Civil Service**
New York State Health Insurance Program

New York State Department of Civil Service
Employee Benefits Division, Albany, New York 12239

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

The SEHP *At A Glance* is published by the Employee Benefits Division of the State of New York Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits. If you have questions, call 1-877-7-NYSHIP (1-877-769-7447) and choose the program you need.

New York State
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
www.cs.ny.gov

Please do not send mail or correspondence to the return address above. See boxed address on page 23.

Save this document

NEW YORK STATE | **Department of Civil Service**
New York State Health Insurance Program

Information for the Enrollee, Enrolled Spouse/ Domestic Partner and Other Enrolled Dependents

SEHP At A Glance — January 2025

AAG-SEHP-1/25 NY1536

Notice of Access to Women's Health Services

This notice is provided in accordance with the New York State Women's Health and Wellness Act. The Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. The Plan covers services required as a result of such examinations. The Plan covers services required as a result of an acute gynecologic condition. The Plan covers all care related to pregnancy. Benefits for these services are paid according to the terms of network or non-network coverage. Benefits Management Program requirements apply (see page 3).

Annual Notice of Mastectomy and Reconstructive Surgery Benefits

The Plan covers inpatient hospital care for lymph node dissection, lumpectomy and mastectomy for treatment of breast cancer for as long as the physician and patient determine hospitalization is medically necessary. The Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery of the other breast to produce a symmetrical appearance. The Plan also covers treatment for complications of mastectomy, including lymphedema and breast prostheses. Benefits Management Program requirements apply (see page 3).

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. To view a copy of the *SBC*, visit www.cs.ny.gov/sbc/sehp/index.cfm. If you do not have internet access, call 1-877-7-NYSHIP (1-877-769-7447) and select the Medical/Surgical Program to request a copy of the *SBC* for the Student Employee Health Plan.