The Empire Plan: NYS Health Insurance Program

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cs.ny.gov or by calling 1-877-7-NYSHIP (1-877-769-7447).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** (**$500** for enrollees in or equated to Grade 6 and below or earning less than $35,705 for UUP; not applicable to PAs or PEs) per enrollee, per spouse/domestic partner, and per all dependent children combined. Does not apply to care rendered by a facility or by a participating provider, hearing aids, prosthetic wigs, external mastectomy prostheses, emergency services, emergency ambulance services, Managed Physical Medicine Program, or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** per enrollee, per spouse/domestic partner, and per all dependent children combined for non-network Managed Physical Medicine Program. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network Max: Individual **$7,150**/Family **$14,300**. Coinsurance Max: **$3,000** (**$1,500** for enrollees in or equated to Grade 6 and below or earning less than $35,705 for UUP; not applicable to PAs or PEs) per enrollee, per spouse/domestic partner, and per all dependent children combined.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover do not count toward either **out-of-pocket limit**. In-Network Max excludes non-network expenses and ancillary charges. Coinsurance Max excludes facility copays, penalties, and expenses incurred under the Prescription Drug Program, Managed Physical Medicine Program services or Home Care Advocacy Program (HCAP).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.cs.ny.gov **or call 1-877-7-NYSHIP** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating and network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit plus $20 copayment for radiology, lab services, and/or immunizations	20% coinsurance	——————none——————
	Specialist visit	$20 copayment/visit plus $20 copayment for radiology, lab services, and/or immunizations	20% coinsurance	——————none——————
	Other practitioner office visit	$20 copayment/visit plus $20 copayment for radiology, lab services, and/or immunizations	20% coinsurance; 50% coinsurance for Managed Physical Medicine Program	——————none——————
	Preventive care/ screening/ immunization	No charge for preventive services in accordance with the Patient Protection and Affordable Care Act (PPACA).	20% coinsurance; no coverage for adult immunizations	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$20 copayment/office visit; $40 ($30 for NYS CSEA and UCS) copayment/ hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	——————none——————
	Imaging (CT/PET scans, MRIs)	$20 copayment/office visit; $40 ($30 for NYS CSEA and UCS) copayment/ hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Precertification required if not an emergency or an inpatient procedure. If not precertified, the cost will be greater. The test or procedure is not covered if determined not to be medically necessary.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cs.ny.gov.	Level 1 or for most Generic Drugs	30-day supply: $5; Network pharmacy 31-90 day supply: $10; Mail Service or Specialty Pharmacy 31-90 day supply: $5	Claims for your out-of-pocket costs may be eligible for partial reimbursement.	Certain medications require prior authorization for coverage. Copayment waived, at a network pharmacy for: • oral chemotherapy drugs when used to treat cancer, generic oral contraceptive drugs and devices • brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices) • Tamoxifen and Raloxifene when prescribed for the primary prevention of breast cancer There is an ancillary charge for covered brand-name drugs that have a generic equivalent in addition to the Level 3 copayment.
	Level 2, Preferred Drugs or Compound Drugs	30-day supply: $25; network pharmacy 31-90 day supply: $50; Mail Service or Specialty Pharmacy 31-90 day supply: $50		
	Level 3 or Non-preferred Drugs	30-day supply: $45; network pharmacy 31-90 day supply: $90; Mail Service or Specialty Pharmacy 31-90 day supply: $90		
	Specialty drugs	Applicable copayment based on the drug copayment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 copayment/office surgery; $30 copayment/non-hospital outpatient surgery; $60 ($40 for NYS CSEA and UCS) copayment/outpatient hospital surgery	20% coinsurance in an office setting; 10% coinsurance or $75 (whichever is greater)	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
	Physician/ surgeon fees	$20 copayment/surgery	20% coinsurance in an office setting	
If you need immediate medical attention	Emergency room services	$70 ($60 for NYS CSEA and UCS) copayment/visit	$70 ($60 for NYS CSEA and UCS) copayment/ visit	Copayment waived if admitted.
	Emergency medical transportation	$35 copayment/trip	$35 copayment/trip	Not subject to deductible or coinsurance.
	Urgent care	$20 copayment/office visit; $40 ($30 for NYS CSEA and UCS) copayment/outpatient hospital visit; Additional $20 copayment for radiology, lab services, and/or immunizations	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	——————none——————

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	Precertification required; $200 penalty if hospitalization is not precertified.
	Physician/surgeon fee	No charge	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment/visit	20% coinsurance	Pre-certification is required for some mental health and substance abuse services.
	Mental/Behavioral health inpatient services	No charge	10% coinsurance	
	Substance use disorder outpatient services	$20 copayment/visit	20% coinsurance	
	Substance use disorder inpatient services	No charge	10% coinsurance	
If you are pregnant	Prenatal and postnatal care	No charge for routine prenatal and postnatal care	20% coinsurance	————————none————————
	Delivery and all inpatient services	No charge	10% coinsurance; 20% coinsurance for provider services not billed by hospital	Precertification required; $200 penalty if hospitalization is not precertified.
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Precertification required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing.
	Rehabilitation services	$20 copayment/visit	50% coinsurance for office visits under Managed Physical Medicine Program; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.

Common Medical Event	Services You May Need	Your cost if you use: Network Coverage/ Participating Provider	Your cost if you use: Non-network Coverage	Limitations & Exceptions
If you need help recovering or have other special health needs (cont.)	Habilitation services	$20 copayment/visit	50% coinsurance	Home Care Advocacy Program (HCAP) or Managed Physical Medicine Program network allowance depending on the service. No charge when precertified if service is covered under HCAP. No coinsurance maximum for Managed Physical Medicine Program or HCAP services.
	Skilled nursing care	No charge	50% coinsurance; 10% coinsurance in a skilled nursing facility	Limitations and exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission is not precertified. Non-network benefits apply if skilled nursing at home is not precertified. No non-network coverage for the first 48 hours. No coverage for Medicare-primary enrollees.
	Durable medical equipment	No charge	50% coinsurance	Diabetic shoes are covered up to $500 when precertified. Allowance for diabetic shoes purchased at a non-network provider is one pair up to 75% of the network allowance. Precertification required; non-network benefits apply if not precertified.
	Hospice service	No charge	Inpatient: 10% coinsurance; Outpatient: 10% coinsurance or $75, whichever is greater	——————none——————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Custodial care
- Dental care (adult & child), except for the correction of damage caused by an accident
- Long-term care
- Routine eye care (adult & child)
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (with limitations)
- Chiropractic care
- Hearing aids (with limitations)
- Infertility treatment (with limitations)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (covered under HCAP only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see your *General Information Book*. For specific conversion information, contact the plan at 1-877-7-NYSHIP. You may also contact your state insurance department, the U.S. Department of Labor or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate program
- The New York State Department of Civil Service, Employee Benefits Division at 518-457-5754 or 1-800-833-4344
- The New York State Department of Financial Services at 518-474-6600 or 1-800-342-3736
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates at 888-614-5400 or www.communityhealthadvocates.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al [1-877-769-7447].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan pays** $7,040
- ☐ **You pay** $500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$300
Coinsurance	$0
Limits or exclusions	$200
Total	**$500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan pays** $4,860
- ☐ **You pay** $540

Sample care costs:

Prescriptions	$2,800
Medical Equipment & Supplies	$1,300
Office Visits and Procedures	$900
Education	$200
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$40
Total	**$540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.