

October 2023



**NYSHIP**  
New York State  
Health Insurance Program

# HEALTH INSURANCE CHOICES

for 2024

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

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**Selecting a health insurance plan is an important and personal decision. Only you know your family's lifestyle, health, budget and benefit preferences.**

**Here are some questions to ask yourself as you review the information on the following pages:**

What is the premium?

What choice of providers do I have?

Are the providers and facilities I currently use considered in- or out-of-network?

Is the medicine I currently take covered? What is my share of the cost?

What benefits are available for a catastrophic illness or injury?

What will happen if I need care while away from home?

Are my special needs covered?

How often do I anticipate needing care? Is there a deductible? What is the annual out-of-pocket maximum?

Are there any benefit limitations?



# IT'S TIME TO REVIEW YOUR Health Plan Options for 2024!

This booklet explains the options available to you under the New York State Health Insurance Program (NYSHIP) for your health insurance and other elections.

Research your choices carefully. You may not change your option after the deadline, except in special circumstances (see your *General Information Book* for details).

The 2024 option-change deadline will be announced once rates for the upcoming plan year have been approved.

If you continue to have questions after you have read this booklet, contact your Health Benefits Administrator (HBA), The Empire Plan program administrators or the HMOs directly.

**Note:** NYSHIP does not offer an open enrollment period. If you and/or your dependents are eligible for NYSHIP coverage but are not enrolled, see your *General Information Book* for information regarding enrollment and situations in which a late enrollment waiting period applies.

# REMINDERS

## NEW IN 2024 FOR THE EMPIRE PLAN

For 2024, the **maximum out-of-pocket limit** for covered, in-network services under The Empire Plan is \$4,000 for Individual coverage and \$8,000 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Use and Prescription Drug programs. See page 23 for more information about how out-of-pocket limits apply to each Empire Plan program.

**NOTE:** *These amounts are applicable to NYSHIP enrollees in negotiating units that currently have an agreement/award with New York State. Enrollees in negotiating units that do not have an agreement/award with New York State as of the date this booklet was printed should refer to the Health Insurance Choices for 2024 Supplement for this information. Your maximum out-of-pocket limit is also noted on your Empire Plan benefit card for easy reference.*



## IF YOU DECIDE TO CHANGE YOUR OPTION

If you decide to change your option, submit a completed *NYS Health Insurance Transaction Form (PS-404)* to your Health Benefits Administrator (HBA) or make the change online using MyNYSHIP\* before the Option Transfer deadline announced in the rate flyer.

If you would like to newly enroll in the Opt-out Program, you must also complete and submit an *Opt-out Attestation Form (PS-409)*. See page 12 for details.

## IF YOU PLAN TO RETIRE OR VEST IN 2024

If you continue your NYSHIP enrollment as a retiree or vestee, you may change your health insurance option when your status changes and, thereafter, at any time once during a 12-month period, for any reason.

**Note:** In certain circumstances, you may be allowed to change your option more than once during a single 12-month period. See your *General Information Book* for details.

If you are planning to retire or vest in 2024, take the time now to familiarize yourself with the eligibility requirements for continuing your health insurance coverage. Refer to your *General Information Book* and ask your HBA for copies of *Planning for Retirement* and *Choices for 2024 for Retirees*.



## LET YOUR AGENCY KNOW ABOUT CHANGES

You must notify your HBA of any changes to your enrollment record (home address, phone number, marital status, dependent eligibility) in a timely manner. Changes in your family status, such as the addition or loss of a dependent, may mean that you need to change your health insurance coverage from Individual to Family or from Family to Individual. If you submit a request within 30 days of a change in family status, you may make these coverage changes without being subject to a late enrollment waiting period. See your *General Information Book* for details. Promptly inform your HBA about any change to ensure it is effective on the actual date of change in family status. If you are registered for MyNYSHIP,\* you may also make address and option changes online.

\* You must be an active employee of a New York State agency and have a personal NY.gov ID to access MyNYSHIP. MyNYSHIP is not available to active employees of Participating Employers (PEs) and cannot be used to elect the Opt-out Program.

# COST OF COVERAGE

## 2024 HEALTH PLAN RATES

The 2024 health plan rates will be mailed to your home and posted on NYSHIP Online as soon as they have been approved. **Note:** Participating Employers (PEs), such as the Thruway Authority and the Metropolitan Transportation Authority, will notify their enrollees of 2024 rates.

The rates flyer announces the option-change deadline and dates on which changes in health insurance payroll deductions will occur. You will have 30 days from the date your agency receives the rate information to submit any changes.

## THE PRE-TAX CONTRIBUTION PROGRAM

*COBRA and Young Adult Option enrollees are not eligible to participate in the Pre-Tax Contribution Program (PTCP). The following also does not apply to enrollees of PEs. PEs that participate in a pre-tax contribution program will provide specific pre-tax information to their employees.*

The Pre-Tax Contribution Program (PTCP) is a voluntary program that allows employees to have their share of the health insurance premium deducted from their wages before taxes are withheld, which in turn may lower tax liability.

Employees must initially decide whether to participate in PTCP when first eligible for NYSHIP health coverage. Subsequently, they may change their PTCP status each year during the PTCP Election Period.

Your current PTCP status is noted on your paycheck.

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



The PTCP Election Period runs concurrently with the annual Option Transfer Period. Dates will be announced once rates have been approved. Per Internal Revenue Service (IRS) rules, this election period is the only opportunity for employees to change their PTCP status; arbitrary, mid-year status changes are not allowed.

If you wish to change your PTCP selection for the 2024 plan year, complete and sign a *NYS Health Insurance Transaction Form (PS-404)* and submit it to your Health Benefits Administrator (HBA) any time during the PTCP Election Period. **NO ACTION IS REQUIRED TO KEEP YOUR CURRENT PTCP STATUS.**

For more information about the PTCP, please consult the *Planning for Option Transfer* flyer and your *General Information Book*.



## YOUR SHARE OF THE PREMIUM

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

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

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

| ENROLLEE<br>PAY GRADE | INDIVIDUAL COVERAGE |                | DEPENDENT COVERAGE |                |
|-----------------------|---------------------|----------------|--------------------|----------------|
|                       | State Share         | Employee Share | State Share        | Employee Share |
| Grade 9 and below*    | 88%                 | 12%            | 73%                | 27%            |
| Grade 10 and above*   | 84%                 | 16%            | 69%                | 31%            |

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

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

# COMPARING YOUR NYSHIP HEALTH PLAN OPTIONS

There are two types of health insurance plans available to you under NYSHIP: The Empire Plan and NYSHIP-approved Health Maintenance Organizations (HMOs). Additionally, if you have other employer-sponsored group health coverage available to you, you may be eligible to participate in the Opt-out Program (see page 12 for details).

## THE EMPIRE PLAN VS. NYSHIP HMOs

The first step toward making an informed choice is understanding how the NYSHIP health plans differ from one another.

| EMPIRE PLAN   | HMO   |
|---|---|
| <p><b>Plan Type</b></p> <p>A self-insured Preferred Provider Organization (PPO) plan with features of a managed care system.</p>  | <p><b>Plan Type</b></p> <p>A managed care system in a specific geographic area that provides comprehensive coverage through a network of providers.</p>   |
| <p><b>Service Area</b></p> <p>Benefits for covered services, not just urgent and emergency care, are available worldwide.</p>   | <p><b>Service Area</b></p> <p>Aside from emergencies, coverage for services received outside the service area is limited and at the discretion of the individual HMO.</p>   |
| <p><b>Participating Providers</b></p> <p>Enrollees have access to over 1.2 million network providers and facilities throughout the United States and are not required to choose a Primary Care Physician (PCP) or obtain referrals to see specialists. Certain services require preapproval.</p> <p>For provider information:</p> <ul style="list-style-type: none"> <li>• Visit NYSHIP Online*</li> <li>• Check with the provider/facility directly</li> <li>• Call The Empire Plan toll free at 1-877-7-NYSHIP</li> </ul> | <p><b>Participating Providers</b></p> <p>Enrollees usually choose a PCP from the HMO's network for routine medical care. It may be necessary to obtain referrals to receive services from certain specialists and hospitals.</p> <p>For provider information:</p> <ul style="list-style-type: none"> <li>• Visit HMO websites**</li> <li>• Check with provider/facility directly</li> <li>• Call the HMOs directly**</li> </ul> |
| <p><b>Out-of-Pocket Expenses/Cost Sharing</b></p> <p>Enrollees usually pay a copayment as a per-visit fee. Benefits for covered services obtained from a nonparticipating provider are subject to a deductible and/or coinsurance.</p>  | <p><b>Out-of-Pocket Expenses/Cost Sharing</b></p> <p>Enrollees usually pay a copayment as a per-visit fee or coinsurance. HMOs have no annual deductible. Out-of-network benefits not available.</p>  |

\* The Empire Plan online provider directories are updated regularly and are therefore more current than the printed versions.

\*\* See the individual HMO pages in this booklet for contact information.



## EXCLUSIONS

All plans contain coverage exclusions for certain services and prescription drugs. Additionally, Workers' Compensation-related expenses and custodial care are generally excluded from coverage. For details on a plan's exclusions, read the *Empire Plan Certificate* or the NYSHIP HMO contract or check with the plan directly.

## 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 an *SBC* for The Empire Plan or a NYSHIP HMO, visit [www.cs.ny.gov/sbc](http://www.cs.ny.gov/sbc). 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 Empire Plan. If you need an *SBC* for a NYSHIP HMO, contact the HMO.



### NYSHIP'S YOUNG ADULT OPTION

This option allows unmarried, young adult children (age 29 or younger) of NYSHIP enrollees to purchase their own NYSHIP coverage. During the Young Adult Option Open Enrollment Period (which coincides with the Option Transfer Period), eligible adult children of NYSHIP enrollees can enroll in the Young Adult Option and current Young Adult Option enrollees are able to switch plans. The premium is the full cost of Individual coverage for the NYSHIP option selected.

For more information about the Young Adult Option, go to [www.cs.ny.gov/yao](http://www.cs.ny.gov/yao) or call the Employee Benefits Division at 518-457-5754 or 1-800-833-4344.

### PLAN COMPARISON TOOL

To generate a side-by-side comparison of the benefits provided by the NYSHIP plans in your area, use the Plan Comparison Tool, available on NYSHIP Online. Select the counties in which you live and work and the plans you want to compare to quickly view the benefit information most important to you/your family in a convenient, single-screen format.

## QUESTIONS AND ANSWERS

| QUESTION   | EMPIRE PLAN  | HMO  |
|--|--|--|
| <b>Will I be covered for medically necessary care I receive away from home?</b>  | Yes, coverage is available worldwide. If you use a nonparticipating provider, deductibles, coinsurance and benefit limits may apply.   | You are always covered for emergency care. Some HMOs may provide coverage for urgent or routine care outside the service area or for college students away from home.  |
| <b>If I am diagnosed with a serious illness, can I see a physician or go to a hospital that specializes in my illness?</b> | Yes. If the doctor you choose participates in The Empire Plan, network benefits will apply for covered services. Your hospital benefits will differ depending on whether you choose a network or non-network hospital (see pages 13–14 for details). | You should expect to choose a participating physician and a participating hospital. Under certain circumstances, you may be able to receive a referral to a non-network provider but will need to contact your HMO for prior approval. |
| <b>Can I be sure I will not need to pay more than my copayment(s) when I receive medical services?</b>                     | Your copayment(s) should be your only expense if you receive medically necessary and covered services from a participating provider.   | As long as you receive medically necessary and covered services and obtain any required referrals, your copayment(s) or coinsurance should be your only expense.   |
| <b>Can I use the hospital of my choice?</b>  | Yes. You have coverage worldwide, but you will receive the highest level of benefits at network facilities. See page 13 for details.   | Except in an emergency, you generally do not have coverage at non-network hospitals unless authorized by the HMO.  |
| <b>What kind of physical therapy, occupational therapy and chiropractic care is available?</b>                             | You have guaranteed access to unlimited, medically necessary care.   | Coverage is available for a specified number of days/visits each year.   |
| <b>What if I need durable medical equipment, medical supplies or home nursing?</b>   | Through the Home Care Advocacy Program (HCAP), benefits for home care, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies) and enteral formulas are paid in full. Prior authorization is required.       | Benefits are available, vary depending on the HMO and may require a greater percentage of cost sharing.  |

**Note:** These responses are generic and highlight only general differences between The Empire Plan and NYSHIP HMOs. Details for each plan are available beginning on page 13 of this booklet, as well as in the *Empire Plan Certificate* and individual HMO contracts.

## BENEFITS OVERVIEW

### THE EMPIRE PLAN PROVIDES:

- Network and non-network inpatient and outpatient hospital coverage for medical, surgical and maternity care
- Center of Excellence Programs for cancer, transplants, infertility and substance use disorder\*
- 24-hour Empire Plan NurseLine<sup>SM</sup> for health information and support
- Worldwide coverage

\* Benefits through the Center of Excellence for Substance Use Disorder Program are only available to Empire Plan-primary enrollees in groups with benefit changes effective July 1, 2023 or later.

### EACH NYSHIP HMO PROVIDES:

- Inpatient and outpatient hospital care at a network hospital
- A specific package of health services, including hospital, medical, surgical and preventive care benefits, provided or arranged by the Primary Care Physician (PCP) selected by the enrollee from the HMO's network
- A unique wellness benefit that rewards enrollees for engaging in healthy activities

### ALL PLANS PROVIDE:

- Preventive care services
- Inpatient medical/surgical hospital care
- Outpatient medical/surgical hospital services
- Physician services
- Emergency care
- Laboratory services
- Radiology services
- Chemotherapy
- Radiation therapy
- Dialysis
- Diagnostic services
- Diabetic supplies
- Maternity, prenatal care
- Well-child care
- Chiropractic services
- Skilled nursing facility services
- Physical therapy
- Occupational therapy
- Speech therapy
- Prosthetics and durable medical equipment
- Orthotic devices
- Medically necessary bone density tests
- Mammography
- Inpatient mental health services
- Outpatient mental health services
- Alcohol and substance use detoxification
- Inpatient alcohol rehabilitation
- Inpatient drug rehabilitation
- Outpatient alcohol and drug rehabilitation
- Family planning and certain infertility services
- Out-of-area emergencies
- Hospice benefits (at least 210 days)
- Home health care in lieu of hospitalization
- Prescription drug coverage, including injectable and self-injectable medications, vaccines, contraceptive drugs and devices and fertility drugs (unless you have coverage through a union Employee Benefit Fund)
- Enteral formulas covered through either The Empire Plan's Home Care Advocacy Program (HCAP) or the NYSHIP HMO's prescription drug program (unless you have coverage through a union Employee Benefit Fund)
- Second opinion for cancer diagnosis
- Gender affirming care
- In vitro fertilization (up to 3 cycles)
- Fertility preservation
- Telehealth

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

## PLANS BY COUNTY

The Empire Plan is available to all enrollees in the New York State Health Insurance Program (NYSHIP) regardless of where you live or work. Coverage is worldwide.

Many NYSHIP enrollees have a choice among HMOs. You may enroll or continue to be enrolled in any NYSHIP-approved HMO that serves the area where you live or work. You may not be enrolled in an HMO outside your area. This list shows which HMOs are available in each county. Medicare-primary NYSHIP HMO enrollees will be enrolled in their HMO's Medicare Advantage Plan.

|  |  |
|--|--|
| <b>Albany:</b> Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)   | <b>Erie:</b> Highmark BCBS of Western New York (067), Independent Health (059)                   |
| <b>Allegany:</b> Highmark BCBS of Western New York (067), Independent Health (059)             | <b>Essex:</b> CDPHP (300), HMOBlue (160), MVP (360)  |
| <b>Bronx:</b> HIP (050)  | <b>Franklin:</b> CDPHP (300), HMOBlue (160), MVP (360)   |
| <b>Broome:</b> CDPHP (300), HMOBlue (072), MVP (330)   | <b>Fulton:</b> Highmark BS of Northeastern New York (069), CDPHP (063), HMOBlue (160), MVP (060) |
| <b>Cattaraugus:</b> Highmark BCBS of Western New York (067), Independent Health (059)          | <b>Genesee:</b> Highmark BCBS of Western New York (067), Independent Health (059), MVP (058)     |
| <b>Cayuga:</b> HMOBlue (072), MVP (330)  | <b>Greene:</b> Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)     |
| <b>Chautauqua:</b> Highmark BCBS of Western New York (067), Independent Health (059)           | <b>Hamilton:</b> CDPHP (300), HMOBlue (160), MVP (060)   |
| <b>Chemung:</b> HMOBlue (072), MVP (058)   | <b>Herkimer:</b> CDPHP (300), HMOBlue (160), MVP (330)   |
| <b>Chenango:</b> CDPHP (300), HMOBlue (160), MVP (330)   | <b>Jefferson:</b> CDPHP (300), HMOBlue (160), MVP (330)  |
| <b>Clinton:</b> CDPHP (300), HMOBlue (160), MVP (360)  | <b>Kings:</b> HIP (050)  |
| <b>Columbia:</b> Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060) | <b>Lewis:</b> CDPHP (300), HMOBlue (160), MVP (330)  |
| <b>Cortland:</b> HMOBlue (072), MVP (330)  | <b>Livingston:</b> BlueChoice (066), MVP (058)   |
| <b>Delaware:</b> CDPHP (310), HIP (350), HMOBlue (160), MVP (330)                              | <b>Madison:</b> CDPHP (300), HMOBlue (160), MVP (330)  |
| <b>Dutchess:</b> CDPHP (310), HIP (350), MVP (340)   | <b>Monroe:</b> BlueChoice (066), MVP (058)   |

**Montgomery:** Highmark BS of Northeastern New York (069), CDPHP (063), HMOBlue (160), MVP (060)

**Nassau:** HIP (050)

**New York:** HIP (050)

**Niagara:** Highmark BCBS of Western New York (067), Independent Health (059)

**Oneida:** CDPHP (300), HMOBlue (160), MVP (330)

**Onondaga:** HMOBlue (072), MVP (330)

**Ontario:** Blue Choice (066), MVP (058)

**Orange:** CDPHP (310), HIP (350), MVP (340)

**Orleans:** Highmark BCBS of Western New York (067), Independent Health (059), MVP (058)

**Oswego:** HMOBlue (072), MVP (330)

**Otsego:** CDPHP (300), HMOBlue (160), MVP (330)

**Putnam:** HIP (350), MVP (340)

**Queens:** HIP (050)

**Rensselaer:** Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)

**Richmond:** HIP (050)

**Rockland:** MVP (340)

**Saratoga:** Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)

**Schenectady:** Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)

**Schoharie:** CDPHP (063), MVP (060)

**Schuyler:** HMOBlue (072), MVP (058)

**Seneca:** Blue Choice (066), MVP (058)

**St. Lawrence:** CDPHP (300), HMOBlue (160), MVP (360)

**Steuben:** HMOBlue (072), MVP (058)

**Suffolk:** HIP (050)

**Sullivan:** HIP (350), MVP (340)

**Tioga:** CDPHP (300), HMOBlue (072), MVP (330)

**Tompkins:** HMOBlue (072), MVP (330)

**Ulster:** CDPHP (310), HIP (350), MVP (340)

**Warren:** Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)

**Washington:** Highmark BS of Northeastern New York (069), CDPHP (063), HIP (220), MVP (060)

**Wayne:** Blue Choice (066), MVP (058)

**Westchester:** HIP (050), MVP (340)

**Wyoming:** Highmark BCBS of Western New York (067), Independent Health (059), MVP (058)

**Yates:** Blue Choice (066), MVP (058)

# THE OPT-OUT PROGRAM NYSHIP CODE #700

The Opt-out Program is available to eligible employees who have other employer-sponsored group health coverage. If eligible, you may opt out of NYSHIP coverage in exchange for an incentive payment. **Note:** Employees who are represented by UUP are not eligible to participate in this program. The State Opt-out Program also is not available to employees of Participating Employers (PEs); however, a PE may offer a similar option or buyout.

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

**It is not necessary to reenroll in the Opt-out Program each year.** *No action is required for current Opt-out enrollees who are still eligible and wish to remain in the Program for the 2024 plan year.*

## ELIGIBILITY REQUIREMENTS

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

- Have been enrolled in the Opt-out Program for the prior plan year or
- Have been enrolled in a NYSHIP health plan by April 1, 2023 (or on your first date of NYSHIP eligibility if that date is later than April 1) and remained continuously enrolled while eligible for the employee share of the premium through the end of 2023.

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

An individual cannot be enrolled in more than one NYSHIP option in their own right as an employee. Since the Opt-out Program is considered a NYSHIP option, an individual cannot opt out through one employer and be enrolled in NYSHIP health benefits in their own right through another employer.

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

**Before requesting enrollment in the Opt-out Program, find out whether the other employer-sponsored plan will permit you to enroll as a dependent. You are responsible for making sure that your other coverage is in effect during the period you opt out of NYSHIP.**

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

## ELECTING TO OPT OUT

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

To elect the Opt-out Program, you must complete a *NYS Health Insurance Transaction Form (PS-404)* and an *Opt-out Attestation Form (PS-409)* and submit both to your HBA. Your NYSHIP coverage will terminate at the end of the current plan year, and the incentive payments will begin with the first pay period affecting coverage for 2024.

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

# THE EMPIRE PLAN NYSHIP CODE #001

This section summarizes benefits available under each portion of The Empire Plan as of January 1, 2024.<sup>1</sup> Visit NYSHIP Online or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) for additional information on the following programs.

**Note:** Employees represented by C-82, DC-37, NYSCOPBA, PBA, PBANYS and PIA should refer to the companion publication entitled **Health Insurance Choices for 2024 Supplement** for information about 2024 Empire Plan benefits, including copayments, coinsurance and deductibles.

## MEDICAL/SURGICAL PROGRAM

Medical and surgical coverage through:

- **Participating Provider Program** – The Participating Provider Program network administered by UnitedHealthcare includes over 1.2 million physicians, laboratories and other providers, such as physical therapists, occupational therapists and chiropractors, located throughout the United States. Certain services are subject to a \$25 copayment.
- **Basic Medical Program** – If you use a nonparticipating provider, covered expenses are reimbursed under the Empire Plan’s Basic Medical Program, subject to deductible and coinsurance.
- **Basic Medical Provider Discount Program** – If you are Empire Plan primary and use a nonparticipating provider who is part of the Empire Plan MultiPlan group, your out-of-pocket costs may be lower (see page 16).
- **Home Care Advocacy Program (HCAP)** – Benefits for home care, durable medical equipment and certain medical supplies (including diabetic and ostomy supplies), enteral formulas and diabetic shoes are paid in full. Prior authorization is required. Guaranteed access to network benefits nationwide. Limited non-network benefits available (see the *Empire Plan Certificate* for details).
- **Managed Physical Medicine Program (MPMP)** – Chiropractic treatment, physical therapy and occupational therapy through a network provider are subject to a \$25 copayment. Unlimited network benefits when medically necessary. Guaranteed access to network benefits nationwide. Non-network benefits available.

- **Benefits Management Program** – You must call the Medical/Surgical Program for Prospective Procedure Review before an elective (scheduled) magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT) scan, positron emission tomography (PET) scan or nuclear medicine test, unless you are having the test as an inpatient in a hospital (see the *Empire Plan Certificate* for details).

When arranged by the Medical/Surgical Program, a voluntary, paid-in-full specialist consultant evaluation is available. Voluntary outpatient medical case management is available to help coordinate services for catastrophic and complex cases.

## HOSPITAL PROGRAM

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

- Inpatient hospital stays are covered at no cost to you.
- Outpatient hospital and emergency care are subject to network copayments.
- Anesthesiology, pathology and radiology provider charges for covered hospital services are paid in full under the Medical/Surgical Program (if The Empire Plan provides your primary coverage).
- Certain covered outpatient hospital services provided at network hospital extension clinics are subject to outpatient hospital copayments.
- Except as noted above, physician charges received in a hospital setting will be paid in full if the provider is a participating provider under the Medical/Surgical Program. Physician charges for covered services received from a non-network provider will be paid in accordance with the Basic Medical portion of the Medical/Surgical Program.

<sup>1</sup> These benefits are subject to medical necessity and to limitations and exclusions described in the *Empire Plan Certificate*.

If you are an Empire Plan-primary enrollee,<sup>2</sup> you will be subject to 10 percent coinsurance for inpatient stays at a **non-network hospital**. For outpatient services received at a non-network hospital, you will be subject to the greater of 10 percent coinsurance or \$75 per visit. The Empire Plan will begin to cover 100 percent of the billed charges for covered inpatient and outpatient services only after the combined annual coinsurance maximum threshold has been reached.

The Empire Plan will approve network benefits for hospital services received at a non-network facility if:

- Your hospital care is an emergency or urgent
- You do not have access to a network facility within a 30-mile radius or 30-minute travel time from your home address that can provide the medically necessary services that you require
- Another insurer or Medicare provides your primary coverage
- You are in an ongoing course of treatment or are pregnant when a hospital leaves the network

### **Preadmission Certification Requirements**

Under the **Benefits Management Program**, if The Empire Plan is your primary coverage, you must call the Hospital Program for certification of any of the following inpatient stays:

- Before a scheduled (nonemergency) hospital admission (except maternity and detoxification)
- Within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission
- Before admission or transfer to a skilled nursing facility

If you do not follow the preadmission certification requirement for the Hospital Program, you must pay:

- A \$200 hospital penalty (if it is determined any portion was medically necessary) and
- All charges for any day's care determined not to be medically necessary.

Voluntary inpatient medical case management is available to help coordinate services for catastrophic and complex cases.

## **MENTAL HEALTH AND SUBSTANCE USE PROGRAM**

The Mental Health and Substance Use (MHSU) Program offers both network and non-network benefits.

### **Network Benefits**

(unlimited when medically necessary)

If you call the MHSU Program before you receive services, you receive:

- Inpatient services, paid in full
- Crisis intervention, paid in full for up to three visits per crisis; after the third visit, the \$25 copayment per visit applies
- Outpatient services, including office visits, home-based or telephone counseling and nurse practitioner services, for a \$25 copayment per visit
- Intensive Outpatient Program (IOP) with an approved provider for a \$25 copayment per day

### **Non-Network Benefits<sup>3</sup>**

(unlimited when medically necessary)

Covered services received from a nonparticipating practitioner or non-network facility are subject to cost sharing requirements. See Cost Sharing on page 15 for additional information.

Outpatient counseling sessions for family members of an individual being treated for alcohol or substance use are covered for a maximum of 20 visits per year for all family members combined.

### **THE EMPIRE PLAN NURSELINE<sup>SM</sup>**

For health information and support, call The Empire Plan and press or say 5 for the NurseLine<sup>SM</sup>.

Registered nurses are available 24 hours a day, seven days a week. All calls are confidential.

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

<sup>3</sup> You are responsible for ensuring that MHSU Program certification is received for care obtained from a non-network practitioner or facility.



## EMPIRE PLAN COST SHARING

### Plan Providers

Under The Empire Plan, benefits are available for covered services when you use a participating or nonparticipating provider. However, your share of the cost depends on whether the provider you use participates in the Plan. You receive the maximum plan benefits when you use participating providers. For more information, ask your HBA for a copy of *Reporting On Network Benefits* or view it on NYSHIP Online.

**If you use an Empire Plan participating provider or facility**, you pay a copayment for certain services. Some services are covered at no cost to you. The provider or facility files the claim and is reimbursed by The Empire Plan.

Even if there are no network providers in your area, you are guaranteed access to network benefits within the United States and its territories for the following services if you call The Empire Plan at 1-877-769-7447 beforehand to arrange care:

- Mental Health and Substance Use (MHSU) Program services
- Managed Physical Medicine Program (MPMP) services (physical therapy, chiropractic care and occupational therapy)
- Home Care Advocacy Program (HCAP) services (including durable medical equipment)

**If you use a nonparticipating provider or non-network facility**, benefits for covered services are payable under the **Basic Medical Program** and are subject to a deductible and/or coinsurance.

### Annual Maximum Out-of-Pocket Limit

There is a limit on the amount you are expected to pay out of pocket for in-network services and supplies during the plan year. Once you reach the limit, you will have no additional copayments. Please see page 23 for more information.

### Combined Annual Deductible

For Medical/Surgical and MHSU Program services received from a nonparticipating provider or non-network facility, The Empire Plan has a combined annual deductible that must be met before covered

services under the Basic Medical Program and non-network expenses under both the HCAP and MHSU Programs can be reimbursed. See the table on page 16 for 2024 combined annual deductible amounts. The Managed Physical Medicine Program (MPMP) has a separate deductible (\$250 per enrollee, \$250 per enrolled spouse/domestic partner and \$250 per all dependent children combined) that is not included in the combined annual deductible.

After the combined annual deductible has been met, The Empire Plan considers 80 percent of the allowed amount, which is based on 275 percent of the Medicare rates published by the Centers for Medicare & Medicaid Services (CMS), for the Basic Medical Program and non-network practitioner services for the MHSU Program, 50 percent of the network allowance for covered services for non-network HCAP or MPMP services and 90 percent of the billed charges for covered services for non-network approved facility services for the MHSU Program. You are responsible for the remaining 20 percent coinsurance and all charges in excess of the allowed amount for Basic Medical Program and non-network practitioner services, 10 percent for non-network MHSU-approved facility services and the remaining 50 percent of the network allowance for covered, non-network HCAP or MPMP services.

### Combined Annual Coinsurance Maximum

The Empire Plan has a combined annual coinsurance maximum that must be met before covered services under the Basic Medical Program and non-network expenses under the Hospital and MHSU Programs will be fully reimbursed. See the table on page 16 for 2024 combined annual coinsurance maximum amounts.

After you reach the combined annual coinsurance maximum, you will be reimbursed up to 100 percent of covered charges under the Hospital Program and 100 percent of the allowed amount for services covered under the Basic Medical Program and MHSU Program. You are responsible for paying the provider and will be reimbursed by the Plan for covered charges. You are also responsible for paying all charges in excess of the allowed amount.

## 2024 COMBINED ANNUAL DEDUCTIBLE AND ANNUAL COINSURANCE MAXIMUM AMOUNTS

| Enrollee Group/Category   | Combined Annual Deductible | Combined Annual Coinsurance Maximum |
|---|----------------------------|-------------------------------------|
| Enrollee  | \$1,250                    | \$3,750                             |
| Enrolled spouse/domestic partner  | \$1,250                    | \$3,750                             |
| Dependent children combined   | \$1,250                    | \$3,750                             |
| Enrollees <sup>1</sup> in titles equated to Salary Grade 6 and below <sup>2</sup> | \$625                      | \$1,875                             |
| Enrollees <sup>1</sup> represented by UUP who earn less than \$42,252             | \$625                      | \$1,875                             |

<sup>1</sup> And each deductible or coinsurance maximum amount for an enrolled spouse/domestic partner and dependent children combined.

<sup>2</sup> This reduction does not apply to justices or judges.

The combined annual coinsurance maximum will be shared among the Basic Medical Program and non-network coverage under the Hospital Program and MHSU Program. The Managed Physical Medicine Program and HCAP do not have a coinsurance maximum.

### **Basic Medical Provider Discount Program**

If you are Empire Plan primary, the Plan also includes a program to reduce your out-of-pocket costs when you use a nonparticipating provider. The Basic Medical Provider Discount Program offers discounts from certain physicians and providers who are not part of The Empire Plan participating provider network. These providers are part of the nationwide MultiPlan group, a provider organization contracted with UnitedHealthcare. Empire Plan Basic Medical Program provisions apply, and you must meet the combined annual deductible.

Providers in the Basic Medical Provider Discount Program accept a discounted fee for covered services. Your 20 percent coinsurance is based on the lower of the discounted fee or the allowed amount. Under this Program, the provider submits your claims, and UnitedHealthcare pays The Empire Plan portion of the provider fee directly to the provider if the services qualify for the Basic Medical Provider Discount Program. Your explanation of benefits shows the discounted amount applied to billed charges.

To find a provider in the Empire Plan Basic Medical Provider Discount Program, ask if the provider is an Empire Plan MultiPlan provider or call The Empire Plan, choose the Medical/Surgical Program and ask a representative for help. You can also find this information on NYSHIP Online.

## PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program does not apply to those who have drug coverage through a union Employee Benefit Fund. If you are Medicare primary or will be in 2024, ask your HBA for a copy of 2024 Choices for Retirees for information about your coverage under Empire Plan Medicare Rx, a Medicare Part D prescription drug program.

### Advanced Flexible Formulary Drug List

The Empire Plan Prescription Drug Program has a flexible formulary drug list for prescription drugs. Designed to provide enrollees and the Plan with the best value in prescription drug spending, the **Advanced Flexible Formulary** excludes coverage for certain brand-name and generic drugs that have no clinical advantage over other covered medications in the same therapeutic class. View the list on NYSHIP Online.

### Copayments for Covered Drugs

The following copayments apply for covered drugs purchased from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy. Prior authorization is required for certain drugs.

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
- Tamoxifen, raloxifene, anastrozole and exemestane, when prescribed for the primary prevention of breast cancer
- Medications used for emergency contraception and pregnancy termination
- Certain preventive adult vaccines, when administered at a pharmacy that participates in the CVS Caremark National Vaccine Network

When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 or non-preferred copayment, plus the difference in cost between the brand-name drug and the generic equivalent (or “ancillary charge”), not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Advanced Flexible Formulary. Exceptions apply.

## COPAYMENTS FOR COVERED DRUGS

|   |   |       |
|---|---|-------|
| Up to a 30-day Supply from a Network Pharmacy, the Mail Service Pharmacy or the Designated Specialty Pharmacy | Level 1 Drugs or Most <b>Generic</b> Drugs              | \$5   |
|   | Level 2 Drugs, <b>Preferred</b> Drugs or Compound Drugs | \$30  |
|   | Level 3 Drugs or <b>Non-Preferred</b> Drugs             | \$60  |
| 31- to 90-day Supply from a Network Pharmacy  | Level 1 Drugs or Most <b>Generic</b> Drugs              | \$10  |
|   | Level 2 Drugs, <b>Preferred</b> Drugs or Compound Drugs | \$60  |
|   | Level 3 Drugs or <b>Non-Preferred</b> Drugs             | \$120 |
| 31- to 90-day Supply from the Mail Service Pharmacy or the Designated Specialty Pharmacy                      | Level 1 Drugs or Most <b>Generic</b> Drugs              | \$5   |
|   | Level 2 Drugs, <b>Preferred</b> Drugs or Compound Drugs | \$55  |
|   | Level 3 Drugs or <b>Non-Preferred</b> Drugs             | \$110 |

You can use a non-network pharmacy or pay out of pocket at a network pharmacy (instead of using your Empire Plan Benefit Card) and submit a claim form for reimbursement. In almost all cases, you will not be reimbursed the total amount you paid for the prescription and your out-of-pocket expenses may exceed the usual copayment amount. To reduce your out-of-pocket expenses, use your Empire Plan Benefit Card whenever possible.

### **Annual Maximum Out-of-Pocket Limit**

There is a limit on the amount you are expected to pay out of pocket for covered prescription drugs received from a network pharmacy during the plan year. Once you reach the limit, you will have no additional copayments for prescription drugs. Please see page 23 for more information.

### **Specialty Pharmacy Program**

CVS Caremark Specialty Pharmacy is the designated pharmacy for The Empire Plan Specialty Pharmacy Program. The Program provides enhanced services

to individuals using specialty drugs (such as those used to treat complex conditions and those that require special handling, special administration or intensive patient monitoring), including disease and drug education; compliance, side effect and safety management; expedited, scheduled delivery of medications at no additional charge; refill reminder calls; and coordination of all necessary supplies (such as needles and syringes) applicable to the medication. Under the Program, you are covered for an initial 30-day fill of most specialty medications at a retail pharmacy, but all subsequent fills must be obtained through CVS Caremark Specialty Pharmacy. When CVS Caremark dispenses a specialty medication, the applicable mail service copayment is charged. The complete list of specialty drugs included in the Program is available on NYSHIP Online. To get started with CVS Caremark Specialty Pharmacy, request refills or speak to a specialty-trained pharmacist or nurse, call The Empire Plan, choose the Prescription Drug Program and ask to speak with Specialty Customer Care.



# CONTACT THE EMPIRE PLAN

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: <https://nyrmo.optummessenger.com/public/opensubmit>

## ► PRESS OR SAY 2

### **Hospital Program: Administered by Anthem Blue Cross**

Administrative services are provided by Anthem HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield 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: <https://www.empireblue.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: 1-855-643-1476 P.O. Box 1850, Hicksville, NY 11802

Claims submission fax: 855-378-8309

Online: [www.achievesolutions.net/achievesolutions/en/empireplan/Home.do](http://www.achievesolutions.net/achievesolutions/en/empireplan/Home.do)

## ► 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

Claims submission: P.O. Box 52136, Phoenix, AZ 85072-2136

## ► PRESS OR SAY 5

### **Empire Plan NurseLine<sup>SM</sup>: Administered by UnitedHealthcare**

Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.

## THE EMPIRE PLAN

For employees of the State of New York who are Management/Confidential; represented by CSEA, PEF and UUP; justices, judges and nonjudicial employees of the Unified Court System (UCS); Legislature; employees of Participating Employers; and their enrolled dependents, COBRA enrollees with their NYSHIP benefits and Young Adult Option enrollees.

| Benefits   | Network Hospital Benefits <sup>1,2</sup>       | Participating Provider <sup>2</sup>   | Nonparticipating Provider  |
|--|--|---|--|
| <b>Office Visits<sup>2</sup></b>                                 |  | \$25 per visit  | Basic Medical <sup>3</sup>   |
| <b>Specialty Office Visits<sup>2</sup></b>                       |  | \$25 per visit  | Basic Medical <sup>3</sup>   |
| <b>Diagnostic Services:<sup>2</sup></b>                          |  |   |  |
| Radiology  | \$40 <sup>4</sup> or \$50 per outpatient visit | \$25 per visit  | Basic Medical <sup>3</sup>   |
| Lab Tests  | \$40 <sup>4</sup> or \$50 per outpatient visit | \$25 per visit  | Basic Medical <sup>3</sup>   |
| Pathology  | No copayment                                   | \$25 per visit  | Basic Medical <sup>3</sup>   |
| EKG/EEG  | \$40 <sup>4</sup> or \$50 per outpatient visit | \$25 per visit  | Basic Medical <sup>3</sup>   |
| Radiation, Chemotherapy, Dialysis                                | No copayment                                   | No copayment  | Basic Medical <sup>3</sup>   |
| <b>Women's Health Care/<br/>Reproductive Health:<sup>2</sup></b> |  |   |  |
| Well-Woman Exams   |  | No copayment  | Basic Medical <sup>3</sup>   |
| Screenings and<br>Maternity-Related Lab Tests                    | \$40 <sup>4</sup> or \$50 per outpatient visit | \$25 per visit  | Basic Medical <sup>3</sup>   |
| Mammograms   | No copayment                                   | No copayment  | Basic Medical <sup>3</sup>   |
| Pre/Postnatal Visits   |  | No copayment <sup>5</sup>   | Basic Medical <sup>3</sup>   |
| Bone Density Tests   | \$40 <sup>4</sup> or \$50 per outpatient visit | \$25 per visit  | Basic Medical <sup>3</sup>   |
| Breastfeeding Services<br>and Equipment                          |  | No copayment for pre/postnatal<br>counseling and equipment purchased<br>from a participating provider; one<br>double-electric breast pump per birth |  |
| External Mastectomy Prosthesis                                   |  | No network benefit. See<br>nonparticipating provider.   | Paid-in-full benefit for one single or<br>double prosthesis per calendar year<br>under Basic Medical, not subject to<br>deductible or coinsurance <sup>6</sup> |
| <b>Family Planning Services<sup>2</sup></b>                      |  | \$25 per visit  | Basic Medical <sup>3</sup>   |

|  |   |   |   |
|--|---|---|---|
| <b>Infertility Services</b>                | \$40 <sup>4</sup> or \$50 per outpatient visit <sup>7</sup>                       | \$25 per visit; no copayment at designated Centers of Excellence <sup>7</sup>     | Basic Medical <sup>3</sup>  |
| <b>Contraceptive Drugs and Devices</b>     |   | No copayment for certain FDA-approved oral contraception methods and counseling   | Basic Medical <sup>3</sup>  |
| <b>Inpatient Hospital Surgery</b>          | No copayment <sup>8</sup>   | No copayment  | Basic Medical <sup>3</sup>  |
| <b>Outpatient Surgery</b>                  | \$75 <sup>4</sup> or \$95 per visit   | \$50 per visit <sup>9</sup>   | Basic Medical <sup>3</sup>  |
| <b>Weight Loss/Bariatric Surgery</b>       | Applicable Inpatient Hospital Surgery or Outpatient Surgery copayment (see above) | Applicable Inpatient Hospital Surgery or Outpatient Surgery copayment (see above) | Basic Medical <sup>3</sup>  |
| <b>Emergency Department</b>                | \$90 <sup>4</sup> or \$100 per visit <sup>10</sup>                                | No copayment  | Basic Medical <sup>3,11</sup>   |
| <b>Urgent Care</b>                         | \$40 <sup>4</sup> or \$50 per outpatient visit <sup>12</sup>                      | \$30 per visit <sup>13</sup>  | Basic Medical <sup>3</sup>  |
| <b>Ambulance</b>                           | No copayment <sup>14</sup>  | \$70 per trip <sup>15</sup>   | \$70 per trip <sup>15</sup>   |
| <b>Telehealth<sup>16</sup></b>             |   | \$25 per visit  | Basic Medical <sup>3</sup>  |
| <b>Mental Health Practitioner Services</b> |   | \$25 per visit  | Applicable annual deductible, 80% of allowed amount; after applicable coinsurance max, 100% of allowed amount (see pages 15–16 for details) |

<sup>1</sup> Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical/Surgical Program. Non-network hospital coverage provided subject to coinsurance (see page 14).

<sup>2</sup> Copayment waived for preventive services under the PPACA. See [www.hhs.gov/healthcare/about-the-aca/preventive-care](http://www.hhs.gov/healthcare/about-the-aca/preventive-care) or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

<sup>3</sup> See Cost Sharing (beginning on page 15) for Basic Medical information.

<sup>4</sup> For enrollees represented by CSEA and UCS enrollees only.

<sup>5</sup> Routine obstetrical ultrasounds may be subject to a \$25 copayment.

<sup>6</sup> Any single external mastectomy prosthesis costing \$1,000 or more requires prior approval.

<sup>7</sup> Certain qualified procedures are subject to a \$50,000 lifetime allowance.

<sup>8</sup> Preadmission certification required.

<sup>9</sup> In outpatient surgical locations (Medical/Surgical Program), the copayment for the facility charge is \$50 per visit. In a provider's office, the copayment is \$25 per visit.

<sup>10</sup> Copayment waived if admitted.

<sup>11</sup> Attending emergency department physicians and other providers, including providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and/or pathology services, are covered at no cost to the enrollee. Other providers are considered under the Basic Medical Program and are not subject to deductible or coinsurance.

<sup>12</sup> At a hospital-owned urgent care facility only.

<sup>13</sup> Up to two copayments per service date may apply.

<sup>14</sup> If service is provided by admitting hospital.

<sup>15</sup> Ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and the type of ambulance transportation is required because of an emergency situation.

<sup>16</sup> Copayments are waived for medical and mental health visits accessed through LiveHealth Online, currently administered through Anthem Blue Cross.

## THE EMPIRE PLAN

| Benefits   | Network Hospital Benefits <sup>1,2</sup>  | Participating Provider <sup>2</sup>   | Nonparticipating Provider   |
|--|---|---|---|
| <b>Approved Facility Mental Health Services</b>  |   | No copayment  | 90% of billed charges; after applicable coinsurance max, covered in full (see pages 15–16 for details)                                      |
| <b>Outpatient Drug/Alcohol Rehabilitation</b>  |   | \$25 per day to approved Intensive Outpatient Program                                       | Applicable annual deductible, 80% of allowed amount; after applicable coinsurance max, 100% of allowed amount (see pages 15–16 for details) |
| <b>Inpatient Drug/Alcohol Rehabilitation</b>   |   | No copayment  | 90% of billed charges; after applicable coinsurance max, covered in full (see pages 15–16 for details)                                      |
| <b>Durable Medical Equipment</b>   |   | No copayment (HCAP)   | 50% of network allowance (see the <i>Empire Plan Certificate</i> )  |
| <b>Prosthetics</b>   |   | No copayment <sup>17</sup>  | Basic Medical <sup>3,17</sup> \$1,500 lifetime maximum benefit for prosthetic wigs not subject to deductible or coinsurance                 |
| <b>Orthotic Devices</b>  |   | No copayment <sup>17</sup>  | Basic Medical <sup>3,17</sup>   |
| <b>Rehabilitative Care</b><br>(not covered in a skilled nursing facility if Medicare primary)              | No copayment as an inpatient; \$25 per visit for outpatient physical therapy following related surgery or hospitalization <sup>18</sup> | Physical or occupational therapy \$25 per visit (MPMP)<br><br>Speech therapy \$25 per visit | \$250 annual deductible, 50% of network allowance (MPMP)<br><br>Basic Medical <sup>3</sup>  |
| <b>Diabetic Supplies</b>   |   | No copayment (HCAP)   | 50% of network allowance (see the <i>Empire Plan Certificate</i> )  |
| <b>Insulin and Oral Agents</b><br>(covered under the Prescription Drug Program, subject to drug copayment) |   |   |   |
| <b>Diabetic Shoes</b>  |   | \$500 annual maximum benefit  | 75% of network allowance up to an annual maximum benefit of \$500 (see the <i>Empire Plan Certificate</i> )                                 |
| <b>Hospice</b>   | No copayment, no limit  |   | 10% of billed charges up to the combined annual coinsurance maximum   |



|  |  |   |   |
|--|--|---|---|
| <b>Skilled Nursing Facility</b> <sup>19,20</sup>   | No copayment   |   | 10% of billed charges up to the combined annual coinsurance maximum                             |
| <b>Prescription Drugs</b><br>(see pages 17–18):  |  |   |   |
| Specialty Drugs (see page 18)  |  |   |   |
| <b>Additional Benefits:</b>  |  |   |   |
| Dental (preventive)  |  | Not covered   | Not covered   |
| Vision (routine only)  |  | Not covered   | Not covered   |
| Hearing Aids   |  | No network benefit.<br>See nonparticipating provider. | Up to \$1,500 per aid per ear every 4 years (every 2 years for children) if medically necessary |
| Annual Out-of-Pocket Maximum   | Individual coverage: \$1,400 for the Prescription Drug Program. <sup>20</sup><br>\$2,600 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Use Programs.<br><br>Family coverage: \$2,800 for the Prescription Drug Program. <sup>20</sup><br>\$5,200 shared maximum for the Hospital, Medical/Surgical and Mental Health/Substance Use Programs. |   | Not available   |
| Out-of-Area Benefit  | Benefits for covered services are available worldwide.   |   |   |
| 24-hour NurseLine <sup>SM</sup> for health information and support at 1-877-7-NYSHIP (1-877-769-7447); press or say 5.   |  |   |   |
| Voluntary disease management programs available for conditions such as asthma, attention deficit hyperactivity disorder (ADHD), cardiovascular disease (CAD), chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), congestive heart failure, depression, diabetes and eating disorders. |  |   |   |
| Diabetes education centers for enrollees who have a diagnosis of diabetes.   |  |   |   |
| For more information regarding covered vaccines, tests and screenings, see the <i>Empire Plan Preventive Care Coverage Guide</i> on NYSHIP Online under Publications or visit <a href="http://www.hhs.gov/healthcare/about-the-aca/preventive-care">www.hhs.gov/healthcare/about-the-aca/preventive-care</a> . |  |   |   |

<sup>1</sup> Inpatient stays at network hospitals are paid in full. Provider charges are covered under the Medical/Surgical Program. Non-network hospital coverage provided subject to coinsurance (see page 14).

<sup>2</sup> Copayment waived for preventive services under the PPACA. See [www.hhs.gov/healthcare/about-the-aca/preventive-care](http://www.hhs.gov/healthcare/about-the-aca/preventive-care) or NYSHIP Online for details. Diagnostic services require plan copayment or coinsurance.

<sup>3</sup> See Cost Sharing (beginning on page 15) for Basic Medical information.

<sup>17</sup> Benefit paid up to cost of device meeting individual's functional need.

<sup>18</sup> Physical therapy must begin within six months of the related surgery or hospitalization and be completed within 365 days of the related surgery or hospitalization.

<sup>19</sup> Up to 120 benefit days; Benefits Management Program provisions apply.

<sup>20</sup> Does not apply to Medicare-primary enrollees.

| BENEFITS  | ENROLLEE COST   |
|---|---|
| <b>Office Visits</b>  | \$25 per visit<br>(\$5 for children to age 26)                                      |
| Annual Adult Routine Physicals  | No copayment  |
| Well Child Care   | No copayment  |
| <b>Specialty Office Visits</b>  | \$40 per visit  |
| <b>Diagnostic/Therapeutic Services</b>                                      |   |
| Radiology   | \$40 per visit  |
| Lab Tests   | No copayment  |
| Pathology   | No copayment  |
| EKG/EEG   | No copayment  |
| Radiation   | \$25 per visit  |
| Chemotherapy  | \$25 for Rx injection<br>and \$25 office copayments<br>(max two copayments per day) |
| Dialysis  | No copayment  |
| <b>Women's Health Care/Reproductive Health</b>                              |   |
| Pap Tests   | No copayment  |
| Mammograms  | No copayment  |
| Prenatal Visits   | No copayment  |
| Postnatal Visits  | No copayment  |
| Bone Density Tests  | No copayment (routine)<br>\$40 copayment (diagnostic)                               |
| Breastfeeding Services<br>and Equipment                                     | No copayment  |
| Must be obtained from a participating<br>Durable Medical Equipment provider |   |
| External Mastectomy Prosthesis  | No copayment  |
| <b>Family Planning Services</b>   | \$25 PCP,<br>\$40 specialist per visit  |
| <b>Infertility Services</b>   | Applicable physician/<br>facility copayment   |
| <b>Contraceptive Drugs</b>  | Applicable Rx copayment <sup>1</sup>  |
| <b>Contraceptive Devices</b>  | Applicable Rx copayment <sup>1</sup>  |
| <b>Inpatient Hospital Surgery</b>   |   |
| Physician   | No copayment  |
| Facility  | No copayment  |

| BENEFITS  | ENROLLEE COST  |
|---|--|
| <b>Outpatient Surgery</b>   |  |
| Hospital  | \$50 per visit   |
| Physician's Office  | \$50 copayment<br>or 20% coinsurance, whichever is less  |
| Outpatient Surgery Facility   | \$40 physician and<br>\$50 facility per visit            |
| <b>Weight Loss/Bariatric Surgery</b>  |  |
|   | Applicable surgery<br>copayment                          |
| <b>Emergency Department</b>   |  |
|   | \$100 per visit<br>(waived if admitted within 23 hours)  |
| <b>Urgent Care Facility</b>   |  |
|   | \$35 per visit   |
| <b>Ambulance</b>  |  |
|   | \$100 per trip   |
| <b>Telehealth</b>   |  |
| Virtual Care PCP/Specialist   | \$25 (\$5 to age 26)/<br>\$40 per visit                  |
| MDLIVE®   | No copayment   |
| <b>Outpatient Mental Health</b>   |  |
| Individual  | \$25 per visit (\$5 for children to age 26)<br>unlimited |
| Group   | \$25 per visit (\$5 for children to age 26)<br>unlimited |
| <b>Inpatient Mental Health</b>  |  |
|   | No copayment<br>unlimited                                |
| <b>Outpatient Drug/Alcohol Rehab</b>  |  |
|   | \$25 per visit<br>unlimited (\$5 for children to age 26) |
| <b>Inpatient Drug/Alcohol Rehab</b>   |  |
|   | No copayment<br>unlimited                                |
| <b>Durable Medical Equipment</b>  |  |
|   | 50% coinsurance  |
| <b>Prosthetics</b>  |  |
|   | 50% coinsurance  |
| <b>Orthotics</b>  |  |
|   | 50% coinsurance  |
| <b>Rehabilitative Care, Physical,<br/>Speech and Occupational Therapy</b>                             |  |
| Inpatient, 60 days max  | No copayment   |
| Outpatient Physical or<br>Occupational Therapy,<br>30 visits max for all outpatient services combined | \$40 per visit   |
| Outpatient Speech Therapy,<br>30 visits max for all outpatient services combined                      | \$40 per visit   |

<sup>1</sup> Generic oral contraceptives and certain OTC contraceptive devices are covered in full in accordance with the Affordable Care Act.

## BENEFITS ENROLLEE COST

**Diabetic Supplies** \$25 per item  
up to a 30-day supply

**Insulin and Oral Agents** \$25 per prescription  
up to a 30-day supply

**Diabetic Shoes** 50% coinsurance  
one pair per year when medically necessary

**Hospice**, 210 days max No copayment

**Skilled Nursing Facility** No copayment  
45 days max per admission, 360-day lifetime max

**Prescription Drugs**

|                                 |  |
|---------------------------------|--|
| Retail, 30-day supply           | \$10 Tier 1,<br>\$30 Tier 2, \$50 Tier 3 <sup>2</sup>  |
| Mail Order, up to 90-day supply | \$20 Tier 1,<br>\$60 Tier 2, \$100 Tier 3 <sup>2</sup> |

You can purchase a 90-day supply of a maintenance medication at a retail pharmacy for a \$30, \$90 or \$150 copayment. You are limited to a 30-day supply for the first fill. Coverage includes fertility drugs, injectable and self-injectable medications and enteral formulas.

### Specialty Drugs

Designated specialty drugs are covered only at a network specialty pharmacy and cannot be filled via mail order. A current list of specialty medications and pharmacies is available at [www.excellusbcb.com](http://www.excellusbcb.com).

## ADDITIONAL BENEFITS

### Annual Out-of-Pocket Maximum

(In-Network Benefits).....\$6,350 Individual,  
\$12,700 Family per year

**Dental**<sup>3</sup>.....\$40 per visit

**Vision**<sup>4</sup>.....\$40 per visit;  
one routine exam every two years. Children to age 19 are covered every year.

**Eyewear**.....\$60 reimbursement for adults every 2 years. Children to age 19: 50% coinsurance, one pair per calendar year.

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

**Out of Area**.....Our BlueCard and Away From Home Care Programs cover routine and urgent care while traveling, for students away at school and for families living apart.

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

<sup>3</sup> Coverage for accidental injury to sound and natural teeth and for care due to congenital disease or anomaly; routine care not covered.

<sup>4</sup> Unlimited visits allowed for exams to treat a disease or injury of the eye.

## Maternity

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

## PLAN HIGHLIGHTS FOR 2024

Earn \$500 per family (\$250 employee and \$250 spouse/domestic partner) in dividend dollars each year for performing healthy activities through our online incentive program.

## PARTICIPATING PHYSICIANS

With more than 3,200 providers available, Blue Choice offers you more choice of doctors than any other area HMO.

## AFFILIATED HOSPITALS

All hospitals in the Blue Choice service area are available to you, plus some outside the service area. Please visit [www.excellusbcb.com](http://www.excellusbcb.com) for a list of participating hospitals.

## PHARMACIES AND PRESCRIPTIONS

Fill prescriptions at any of our more than 60,000 participating pharmacies nationwide. Blue Choice offers convenient mail-order services for select maintenance drugs. We offer a **closed formulary**.

## MEDICARE COVERAGE

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

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

## NYSHIP CODE NUMBER 066

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

## BLUE CHOICE

165 Court Street, Rochester, NY 14647

## FOR INFORMATION

**Blue Choice:** 1-800-499-1275

**TTY:** 1-800-662-1220

**Medicare Blue Choice:** 1-877-883-9577

**Website:** [www.excellusbcb.com](http://www.excellusbcb.com)



| BENEFITS                                       | ENROLLEE COST   |
|--|---|
| <b>Office Visits</b>                           | Under age 19: \$0 copayment;<br>Ages 19+: \$15 per visit                |
| Annual Adult Routine Physicals                 | No copayment  |
| Well Child Care                                | No copayment  |
| <b>Specialty Office Visits</b>                 | \$25 per visit  |
| <b>Diagnostic/Therapeutic Services</b>         |   |
| Radiology <sup>1</sup>                         | \$25 per visit <sup>2</sup>   |
| Lab Tests                                      | \$25 per visit <sup>1</sup>   |
| Pathology                                      | \$25 per visit <sup>1</sup>   |
| EKG/EEG  | \$25 per visit <sup>1</sup>   |
| Radiation                                      | \$15 per visit  |
| Chemotherapy                                   | \$15 per visit  |
| Dialysis                                       | \$15 per visit  |
| <b>Women's Health Care/Reproductive Health</b> |   |
| Pap Tests                                      | No copayment  |
| Mammograms                                     | No copayment  |
| Prenatal Visits                                | \$15 copayment for initial visit;<br>no copayment for subsequent visits |
| Postnatal Visits                               | No copayment  |
| Bone Density Tests                             | No copayment  |
| Breastfeeding Services and Equipment           | No copayment  |
| External Mastectomy Prosthesis                 | 50% coinsurance   |
| <b>Family Planning Services</b>                | No copayment  |
| <b>Infertility Services</b>                    | \$25 per visit <sup>3</sup>   |
| <b>Contraceptive Drugs</b>                     | No copayment <sup>4</sup>   |
| <b>Contraceptive Devices</b>                   | No copayment <sup>4</sup>   |
| <b>Inpatient Hospital Surgery</b>              | No copayment  |
| <b>Outpatient Surgery</b>                      |   |
| Hospital                                       | \$100 per visit   |
| Physician's Office                             | \$15 PCP,<br>\$25 Specialist per visit                                  |
| Outpatient Surgery Facility                    | \$100 per visit   |

| BENEFITS   | ENROLLEE COST  |
|--|--|
| <b>Weight Loss/Bariatric Surgery</b>   | \$0 inpatient,<br>\$100 outpatient<br>when medically necessary |
| <b>Emergency Department</b>  | \$100 per visit<br>(waived if admitted within 24 hours)        |
| <b>Urgent Care Facility</b>  | \$25 per visit   |
| <b>Ambulance</b>   | \$50 per trip  |
| <b>Telehealth</b>  |  |
| Virtual Care PCP/Specialist  | \$15/\$25 per visit  |
| Doctor on Demand   | No copayment   |
| apitihealth (Behavioral Health)  | No copayment   |
| <b>Outpatient Mental Health</b>  |  |
| Individual, unlimited  | \$15 per visit   |
| Group, unlimited   | \$15 per visit   |
| <b>Inpatient Mental Health, unlimited</b>                                    | No copayment   |
| <b>Outpatient Drug/Alcohol Rehab</b>   | \$15 per visit<br>unlimited                                    |
| <b>Inpatient Drug/Alcohol Rehab</b>  | No copayment<br>unlimited                                      |
| <b>Durable Medical Equipment</b>   | 50% coinsurance  |
| <b>Prosthetics</b>   | 50% coinsurance  |
| <b>Orthotics<sup>5</sup></b>   | 50% coinsurance  |
| <b>Rehabilitative Care, Physical, Speech and Occupational Therapy</b>        |  |
| Inpatient, 60 days max   | No copayment   |
| Outpatient Physical or Occupational Therapy, 30 visits max per calendar year | \$25 per visit   |
| Outpatient Speech Therapy, 20 visits max per calendar year                   | \$25 per visit   |
| <b>Diabetic Supplies</b>   |  |
| Retail, 30-day supply  | \$15 per item  |
| Mail Order, 90-day supply  | \$30 per item  |

<sup>1</sup> Preauthorization is required for advanced imaging services (CT, MRI, PET and nuclear medicine).

<sup>2</sup> Copayment is waived if utilizing a preferred provider or facility.

<sup>3</sup> May vary depending on place of service.

<sup>4</sup> OTC contraceptives with a written physician order/prescription will be reimbursed at no member cost share. Non-formulary contraceptives require prior authorization to be covered at no copayment. If not approved, 100% member liability applies.

<sup>5</sup> Excludes shoe inserts.

**BENEFITS** **ENROLLEE COST**

|   |  |
|---|--|
| <b>Insulin and Oral Agents</b>  |  |
| Retail, 30-day supply   | \$15 per item <sup>6</sup>   |
| Mail Order, 90-day supply   | \$30 per item  |
| <b>Diabetic Shoes</b>   |  |
| one pair per year when medically necessary  | \$15 per pair  |
| <b>Hospice, 210 days max</b>  |  |
|   | No copayment   |
| <b>Skilled Nursing Facility</b>   |  |
| 45 days max   | No copayment   |
| <b>Prescription Drugs</b>   |  |
| Retail, 30-day supply   | \$5 Tier 1<br>(\$0 Tier 1 for under age 19),<br>\$30 Tier 2, \$50 Tier 3 |
| Mail Order, 90-day supply   | \$10 Tier 1,<br>\$60 Tier 2, \$100 Tier 3                                |
| Over-the-counter formulary drugs are subject to Tier 1 copayment. By law, generics match brand-name strength, purity and stability. Ask your doctor about generic alternatives. |  |

**Specialty Drugs**  
Certain specialty drugs require prior approval, are subject to clinical management programs and must be filled by a network specialty pharmacy.

**ADDITIONAL BENEFITS**

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

**Dental**.....Not covered

**Vision**.....Not covered

**Laser Vision Correction**.....\$750 reimbursement once per lifetime benefit

**Hearing Aids**.....50% coinsurance <sup>7</sup>

**Out of Area**.....Coverage for emergency care as well as preapproved follow-up care for college students.

**Allergy Injections**.....No copayment

**Diabetic Prevention Program**.....No copayment

**Acupuncture**.....\$25 per visit, 10 visits max

**PLAN HIGHLIGHTS FOR 2024**  
\$0 PCP visits and Tier 1 Rx for members under age 19.  
\$0 virtual mental health visits with aptihealth. Up to \$2,640 in wellness benefits, including \$600 fitness reimbursement (youth sports, gyms, fitness classes, activity trackers), \$365 in CDPHP Life Points Rewards

<sup>6</sup> \$15 copayment applies for each 30-day supply of insulin, capped at \$100 total member out-of-pocket cost per 30-day supply. This does not include additional diabetic drugs.  
<sup>7</sup> One per ear, every three years.

redeemable for gift cards, \$100 for weight loss programs, up to \$1,500 per pregnancy for doula services and \$75 maternal health education. College students/travelers can access live video doctor visits and 1,100+ CVS MinuteClinic locations.

**PARTICIPATING PHYSICIANS**  
CDPHP has nearly 24,000 participating practitioners and providers.

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

**PHARMACIES AND PRESCRIPTIONS**  
Visit [www.cdphp.com/stateemployees](http://www.cdphp.com/stateemployees) to find a pharmacy, learn about our discount medication program, download our pharmacy app and more. We offer a **closed formulary**.

**MEDICARE COVERAGE**  
Medicare-primary NYSHIP retirees and dependents must enroll in CDPHP Group Medicare Rx (HMO), our **Medicare Advantage Plan**. To qualify, you must have Medicare Parts A and B and live in the service area.

**Important Note:** Only participating providers in the counties listed below are part of this HMO’s network within NYSHIP. Please be sure to check before receiving care that your provider participates with this HMO’s NYSHIP network.

**NYSHIP CODE NUMBER 063**  
An IPA HMO serving individuals living or working in the following select counties: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

**NYSHIP CODE NUMBER 300**  
An IPA HMO serving individuals living or working in the following select counties: Broome, Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Otsego, St. Lawrence and Tioga.

**NYSHIP CODE NUMBER 310**  
An IPA HMO serving individuals living or working in the following select counties: Delaware, Dutchess, Orange and Ulster.

**CAPITAL DISTRICT PHYSICIANS’ HEALTH PLAN, INC. (CDPHP)**  
500 Patroon Creek Boulevard, Albany, NY 12206-1057

**FOR INFORMATION:**  
**Member Services:** 518-641-3700 or 1-800-777-2273  
**TTY:** 711  
**Website:** [www.cdphp.com/stateemployees](http://www.cdphp.com/stateemployees)



| BENEFITS  | ENROLLEE COST   |
|---|---|
| <b>Office Visits</b>                                | \$5 per visit   |
| Annual Adult Routine Physicals                      | No copayment  |
| Well Child Care                                     | No copayment  |
| <b>Specialty Office Visits</b>                      | \$10 per visit  |
| <b>Diagnostic/Therapeutic Services</b>              |   |
| Radiology   | \$5 PCP visit; \$10 specialist visit  |
| Lab Tests   | \$5 PCP visit; \$10 specialist visit  |
| Pathology   | No copayment  |
| EKG/EEG   | \$5 PCP visit; \$10 specialist visit  |
| Radiation   | \$10 specialist visit   |
| Chemotherapy  | \$5 PCP visit; \$10 specialist visit  |
| Dialysis  | \$5 PCP visit; \$10 specialist visit<br>\$0 freestanding center/outpatient hospital |
| <b>Women's Health Care/Reproductive Health</b>      |   |
| Pap Tests   | No copayment  |
| Mammograms  | No copayment  |
| Prenatal Visits                                     | No copayment  |
| Postnatal Visits                                    | No copayment  |
| Bone Density Tests                                  | No copayment  |
| Breastfeeding Services and Equipment                | No copayment  |
| External Mastectomy Prosthesis                      | No copayment  |
| <b>Family Planning Services</b>                     | \$5 PCP visit,<br>\$10 specialist visit   |
| <b>Infertility Services</b>                         | \$10 per visit  |
| <b>Contraceptive Drugs<sup>1</sup></b>              | No copayment  |
| <b>Contraceptive Devices<sup>1</sup></b>            | No copayment  |
| <b>Inpatient Hospital Surgery</b>                   | No copayment  |
| <b>Outpatient Surgery</b>                           | No copayment  |
| <b>Weight Loss/Bariatric Surgery</b>                | No copayment<br>Preauthorization may be required.                                   |
| <b>Emergency Department</b><br>(waived if admitted) | \$75 per visit  |

| BENEFITS  | ENROLLEE COST   |
|---|---|
| <b>Urgent Care Facility</b>   | \$25 copayment per visit  |
| <b>Ambulance</b>  | No copayment  |
| <b>Telehealth</b>   |   |
| Virtual Care PCP/Specialist   | \$5/\$10 per visit  |
| Virtual Portal  | No coverage   |
| <b>Outpatient Mental Health</b>   | No copayment<br>unlimited   |
| <b>Inpatient Mental Health</b>  | No copayment<br>unlimited   |
| <b>Outpatient Drug/Alcohol Rehab</b>                                      | \$5 per visit<br>unlimited  |
| <b>Inpatient Drug/Alcohol Rehab</b>                                       | No copayment<br>unlimited   |
| <b>Durable Medical Equipment</b>  | No copayment  |
| <b>Prosthetics</b>  | No copayment  |
| <b>Orthotics</b>  | No copayment  |
| <b>Rehabilitative Care, Physical,<br/>Speech and Occupational Therapy</b> |   |
| Inpatient, 30 days max  | No copayment  |
| Outpatient Physical or<br>Occupational Therapy                            | \$5 PCP visit,<br>\$10 specialist visit,<br>\$0 outpatient facility<br>90 visits max for all outpatient rehabilitative care |
| Outpatient Speech Therapy   | \$5 PCP visit,<br>\$10 specialist visit,<br>\$0 outpatient facility<br>90 visits max for all outpatient rehabilitative care |
| <b>Diabetic Supplies</b>  | \$5 per 34-day supply   |
| <b>Insulin and Oral Agents</b>  | \$5 per 34-day supply   |
| <b>Diabetic Shoes<sup>2</sup></b><br>when medically necessary             | No copayment  |
| <b>Hospice, 210 days max</b>  | No copayment  |
| <b>Skilled Nursing Facility</b><br>unlimited                              | No copayment  |

<sup>1</sup> Covered for FDA-approved contraceptive drugs/devices only.

<sup>2</sup> Precertification must be obtained from participating vendor prior to purchase.

## BENEFITS

## ENROLLEE COST

### Prescription Drugs

Retail, 30-day supply \$5 Tier 1, \$20 Tier 2

Mail Order, 90-day supply \$7.50 Tier 1, \$30 Tier 2

Subject to drug formulary, includes fertility drugs, injectable and self-injectable medications and enteral formulas. Copayments reduced by 50 percent when utilizing EmblemHealth mail-order service. Up to a 90-day supply of generic or brand-name drugs may be obtained.

### Specialty Drugs

Coverage provided through the EmblemHealth Specialty Pharmacy Program. Prior approval required; 30-day supply limit.

## ADDITIONAL BENEFITS

### Annual Out-of-Pocket Maximum

(In-Network Benefits).....\$6,850 Individual,  
\$13,700 Family per year

Dental.....Not covered

Vision.....No copayment  
for routine and refractive eye exams

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

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

Hearing Aids.....Cochlear implants only

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

Alternative Medicine Program.....Discount program

Artificial Insemination.....\$10 per visit

Prostate Cancer Screening.....No copayment

## PLAN HIGHLIGHTS FOR 2024

Subscribers who are active members of a fitness center are eligible to receive a \$200 reward (covered dependents eligible for a \$100 reward) for actively working out at least 50 times every six months during the calendar year. Up to one visit per day counts towards the reward requirement.

## PARTICIPATING PHYSICIANS

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

## AFFILIATED HOSPITALS

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

## PHARMACIES AND PRESCRIPTIONS

Filling a prescription is easy with more than 30,000 participating pharmacies nationwide. EmblemHealth Prime members have access to a mail-order program through Express Scripts. Tier 1 includes generic drugs; Tier 2 includes brand-name drugs. We offer a **closed formulary**.

## MEDICARE COVERAGE

Retirees who are not Medicare-eligible are offered the same coverage as active employees. Medicare-primary retirees must enroll in the VIP Premier (HMO) Medicare Plan, a **Medicare Advantage Plan** that provides Medicare benefits and more. To qualify, you must be enrolled in Medicare Parts A and B and live in the service area.

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

### NYSHIP CODE NUMBER 050

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

### NYSHIP CODE NUMBER 220

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

### NYSHIP CODE NUMBER 350

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

## EMBLEMHEALTH

55 Water Street, New York, NY 10041

### FOR INFORMATION:

**Customer Service:** 1-800-447-8255

**TTY:** 1-888-447-4833

**Website:** [www.emblemhealth.com](http://www.emblemhealth.com)



A trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

| BENEFITS   | ENROLLEE COST               |
|--|-----------------------------|
| <b>Office Visits</b>                                   | \$10 per visit <sup>1</sup> |
| Annual Adult Routine Physicals                         | No copayment                |
| Well Child Care  | No copayment                |
| <b>Specialty Office Visits</b>                         | \$15 per visit              |
| <b>Diagnostic/Therapeutic Services</b>                 |                             |
| Radiology  | \$15 per visit              |
| Lab Tests <sup>2</sup>                                 | No copayment                |
| Pathology  | No copayment                |
| EKG/EEG  | \$15 per visit              |
| Radiation  | \$15 per visit              |
| Chemotherapy   | \$15 per visit              |
| Dialysis   | \$10 per visit              |
| <b>Women's Health Care/Reproductive Health</b>         |                             |
| Pap Tests  | No copayment                |
| Mammograms   | No copayment                |
| Prenatal Visits  | \$10 per visit <sup>3</sup> |
| Postnatal Visits                                       | \$10 per visit              |
| Bone Density Tests                                     | No copayment                |
| Breastfeeding Services and Equipment                   | No copayment <sup>4</sup>   |
| External Mastectomy Prosthesis one per breast per year | No copayment                |
| <b>Family Planning Services</b>                        | \$15 per visit              |
| <b>Infertility Services</b>                            | \$15 per visit              |
| <b>Contraceptive Drugs</b>                             | No copayment <sup>5</sup>   |
| <b>Contraceptive Devices</b>                           | No copayment <sup>5</sup>   |
| <b>Inpatient Hospital Surgery</b>                      | No copayment                |

| BENEFITS  | ENROLLEE COST       |
|---|---------------------|
| <b>Outpatient Surgery</b>   |                     |
| Hospital  | \$100 per visit     |
| Physician's Office  | \$15 per visit      |
| Outpatient Surgery Facility   | \$100 per visit     |
| <b>Weight Loss/Bariatric Surgery</b>                                    | \$100 copayment     |
| <b>Emergency Department</b><br>(waived if admitted)                     | \$100 per visit     |
| <b>Urgent Care Facility<sup>6</sup></b>                                 | \$25 per visit      |
| <b>Ambulance</b>  | \$100 per trip      |
| <b>Telehealth</b>   |                     |
| Virtual Care PCP/Specialist with an in-network provider                 | \$10/\$15 per visit |
| myhighmark.com  | No copayment        |
| <b>Outpatient Mental Health</b>   |                     |
| Individual, unlimited   | \$10 per visit      |
| Group, unlimited  | \$10 per visit      |
| <b>Inpatient Mental Health</b><br>unlimited                             | No copayment        |
| <b>Outpatient Drug/Alcohol Rehab</b><br>unlimited                       | \$10 per visit      |
| <b>Inpatient Drug/Alcohol Rehab</b><br>unlimited                        | No copayment        |
| <b>Durable Medical Equipment</b>  | 50% coinsurance     |
| <b>Prosthetics</b>  | 20% coinsurance     |
| <b>Orthotics</b>  | 20% coinsurance     |
| <b>Rehabilitative Care, Physical, Speech and Occupational Therapy</b>   |                     |
| Inpatient, unlimited <sup>7</sup>                                       | No copayment        |
| Outpatient Physical or Occupational Therapy, 20 visits max <sup>8</sup> | \$15 per visit      |
| Outpatient Speech Therapy, 20 visits max <sup>8</sup>                   | \$15 per visit      |

<sup>1</sup> No copayment for primary care visits for children age 19 and under.

<sup>2</sup> Members are required to use Quest Diagnostics or an outpatient hospital that participates as a Quest Diagnostics hospital draw site.

<sup>3</sup> \$10 copayment for the final visit only.

<sup>4</sup> For hospital-grade pump rental, covered for duration of breastfeeding. \$170 allowance towards purchase of one manual/ electric pump per pregnancy.

<sup>5</sup> No copayment for contraceptive drugs and devices unless a generic equivalent is available, in which case you are subject to a \$30 (Tier 2) or \$60 (Tier 3) copayment.

<sup>6</sup> Urgent care is covered worldwide.

<sup>7</sup> Prior authorization is required.

<sup>8</sup> Twenty visits in aggregate for physical therapy, occupational therapy and speech therapy.



## BENEFITS ENROLLEE COST

|  |  |
|--|--|
| <b>Diabetic Supplies</b>   | \$10 per item                                |
| <b>Insulin and Oral Agents</b>                                       | \$10 per item                                |
| <b>Diabetic Shoes</b>  | Not covered                                  |
| <b>Hospice</b>   | No copayment                                 |
| <b>Skilled Nursing Facility</b><br>100 days max per plan year        | No copayment                                 |
| <b>Prescription Drugs</b>  |  |
| Retail, 30-day supply  | \$5 Tier 1,<br>\$30 Tier 2, \$60 Tier 3      |
| Mail Order, 90-day supply  | \$12.50 Tier 1,<br>\$75 Tier 2, \$150 Tier 3 |
| May require prior approval. Over 600 \$0 preventive drugs available. |  |
| <b>Specialty Drugs</b>   |  |
| Available through mail order at the applicable copayment.            |  |

### ADDITIONAL BENEFITS

#### Annual Out-of-Pocket Maximum

(In-Network Benefits).....\$3,000 Individual,  
\$6,000 Family per year

**Dental**.....Not covered

**Vision**.....Eye exams covered in full  
Eyewear discounts available<sup>9</sup>

**Hearing Aids**.....Discounts available<sup>10</sup>

**Out of Area**.....Worldwide coverage for emergency care through the BlueCard Program. Away From Home Care (AFHC) allows you to obtain coverage through a nearby Blue HMO when you are away from home and our service area. Call the number on the back of your ID card for more information.

**In Vitro Fertilization**.....\$15 copayment  
Three treatment rounds of IVF per lifetime max, other artificial means to induce pregnancy (embryo transfer, etc.) are not covered.

**Wellness Services**.....\$600 Single/\$750 Family  
wellness card annual allowance for use at participating vendors. Funds do not roll over.

### PLAN HIGHLIGHTS FOR 2024

Low specialist copayment of \$15. \$0 pediatric primary care visits. Access to over 600 \$0 preventive drugs. Away from Home Care. Discounts on health and wellness services/products through Blue365.

### PARTICIPATING PHYSICIANS

You have access to 11,000+ physicians and healthcare professionals.

### AFFILIATED HOSPITALS

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

### PHARMACIES AND PRESCRIPTIONS

Our network includes 45,000 participating pharmacies. Prescriptions filled up to 31-day supply We offer a **closed formulary**.

### MEDICARE COVERAGE

Medicare-primary enrollees are required to enroll in Senior Blue HMO, our **Medicare Advantage Plan**. To qualify, you must enroll in Medicare Parts A & B and live in the service area.

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

### NYSHIP CODE NUMBER 067

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

### HIGHMARK BLUE CROSS BLUE SHIELD OF WESTERN NEW YORK

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

### FOR INFORMATION:

**Highmark Blue Cross Blue Shield of Western New York:** 1-844-639-2441

**TTY:** 711

**Website:** [www.highmark.com/member/nyship-bcbswny](http://www.highmark.com/member/nyship-bcbswny)

<sup>9</sup> Through Davis Vision providers only.

<sup>10</sup> For more information, visit [www.blue365deals.com/WNY](http://www.blue365deals.com/WNY).



A trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

| BENEFITS   | ENROLLEE COST               |
|--|-----------------------------|
| <b>Office Visits</b>                                   | \$10 per visit <sup>1</sup> |
| Annual Adult Routine Physicals                         | No copayment                |
| Well Child Care  | No copayment                |
| <b>Specialty Office Visits</b>                         | \$15 per visit              |
| <b>Diagnostic/Therapeutic Services</b>                 |                             |
| Radiology  | \$15 per visit              |
| Lab Tests <sup>2</sup>                                 | No copayment                |
| Pathology  | No copayment                |
| EKG/EEG  | \$15 per visit              |
| Radiation  | \$15 per visit              |
| Chemotherapy   | \$15 per visit              |
| Dialysis   | \$10 per visit              |
| <b>Women's Health Care/Reproductive Health</b>         |                             |
| Pap Tests  | No copayment                |
| Mammograms   | No copayment                |
| Prenatal Visits  | \$10 per visit <sup>3</sup> |
| Postnatal Visits                                       | \$10 per visit              |
| Bone Density Tests                                     | No copayment                |
| Breastfeeding Services and Equipment                   | No copayment <sup>4</sup>   |
| External Mastectomy Prosthesis one per breast per year | No copayment                |
| <b>Family Planning Services</b>                        | \$15 per visit              |
| <b>Infertility Services</b>                            | \$15 per visit              |
| <b>Contraceptive Drugs</b>                             | No copayment <sup>5</sup>   |
| <b>Contraceptive Devices</b>                           | No copayment <sup>5</sup>   |
| <b>Inpatient Hospital Surgery</b>                      | No copayment                |

| BENEFITS  | ENROLLEE COST                                   |
|---|---|
| <b>Outpatient Surgery</b>   |   |
| Hospital  | \$100 per visit                                 |
| Physician's Office  | \$15 per visit                                  |
| Outpatient Surgery Facility   | \$100 per visit                                 |
| <b>Weight Loss/Bariatric Surgery</b>                                    | \$100 copayment                                 |
| <b>Emergency Department</b> (waived if admitted)                        | \$100 per visit                                 |
| <b>Urgent Care Facility<sup>6</sup></b>                                 | \$25 per visit                                  |
| <b>Ambulance</b>  | \$100 per trip                                  |
| <b>Telehealth</b>   |   |
| Virtual Care PCP/Specialist   | \$10/\$15 per visit with an in-network provider |
| myhighmark.com  | No copayment                                    |
| <b>Outpatient Mental Health</b>   |   |
| Individual, unlimited   | \$10 per visit                                  |
| Group, unlimited  | \$10 per visit                                  |
| <b>Inpatient Mental Health</b> unlimited                                | No copayment                                    |
| <b>Outpatient Drug/Alcohol Rehab</b> unlimited                          | \$10 per visit                                  |
| <b>Inpatient Drug/Alcohol Rehab</b> unlimited                           | No copayment                                    |
| <b>Durable Medical Equipment</b>  | 50% coinsurance                                 |
| <b>Prosthetics</b>  | 20% coinsurance                                 |
| <b>Orthotics</b>  | 20% coinsurance                                 |
| <b>Rehabilitative Care, Physical, Speech and Occupational Therapy</b>   |   |
| Inpatient, unlimited <sup>7</sup>                                       | No copayment                                    |
| Outpatient Physical or Occupational Therapy, 20 visits max <sup>8</sup> | \$15 per visit                                  |
| Outpatient Speech Therapy, 20 visits max <sup>8</sup>                   | \$15 per visit                                  |

<sup>1</sup> No copayment for primary care visits for children age 19 and under.

<sup>2</sup> Members are required to use Quest Diagnostics or an outpatient hospital that participates as a Quest Diagnostics hospital draw site.

<sup>3</sup> \$10 copayment for the final visit only.

<sup>4</sup> For hospital-grade pump rental, covered for the duration of breast feeding. \$170 allowance towards the purchase of one manual or electric pump per pregnancy.

<sup>5</sup> No copayment for contraceptive drugs and devices unless a generic equivalent is available, in which case you are subject to a \$30 (Tier 2) or \$60 (Tier 3) copayment.

<sup>6</sup> Urgent Care is covered worldwide.

<sup>7</sup> Preauthorization is required.

<sup>8</sup> Twenty visits in aggregate for physical therapy, occupational therapy and speech therapy.

| BENEFITS | ENROLLEE COST |
|----------|---------------|
|----------|---------------|

|  |  |
|--|--|
| <b>Diabetic Supplies</b>   | \$10 per item                                |
| <b>Insulin and Oral Agents</b>                                       | \$10 per item                                |
| <b>Diabetic Shoes</b>  | Not covered                                  |
| <b>Hospice</b>   | No copayment                                 |
| <b>Skilled Nursing Facility</b><br>100 days max per plan year        | No copayment                                 |
| <b>Prescription Drugs</b>  |  |
| Retail, 30-day supply  | \$5 Tier 1,<br>\$30 Tier 2, \$60 Tier 3      |
| Mail Order, 90-day supply  | \$12.50 Tier 1,<br>\$75 Tier 2, \$150 Tier 3 |
| May require prior approval. Over 600 \$0 preventive drugs available. |  |

**Specialty Drugs**  
Available through mail order at the applicable copayment.

### ADDITIONAL BENEFITS

|  |   |
|--|---|
| <b>Annual Out-of-Pocket Maximum</b><br>(In-Network Benefits) | \$3,000 Individual,<br>\$6,000 Family per year  |
| <b>Dental</b>  | Not covered   |
| <b>Vision</b>  | Eye exams covered in full;<br>Eyewear discounts available <sup>9</sup>  |
| <b>Hearing Aids</b>  | Discounts available <sup>10</sup>   |
| <b>Out of Area</b>   | Worldwide coverage for emergency care through the BlueCard Program. Away From Home Care (AFHC) allows you to obtain coverage through a nearby Blue HMO when you are away from home and our service area. For more information, call the number on the back of your ID card. |
| <b>In Vitro Fertilization</b>                                | \$15 copayment<br>Three treatment rounds of IVF per lifetime max, other artificial means to induce pregnancy (embryo transfer, etc.) are not covered.   |
| <b>Wellness Services</b>                                     | \$600 Single/\$750 Family<br>wellness card annual allowance for use at participating facilities. Funds do not roll over.  |

<sup>9</sup> Through Davis Vision providers only.

<sup>10</sup> For more information, visit [www.blue365deals.com/BSNENY](http://www.blue365deals.com/BSNENY).

### PLAN HIGHLIGHTS FOR 2024

Low specialist copayment of \$15. \$0 pediatric primary care visits. Access to over 600 \$0 preventive drugs. Away from Home Care. Discounts on health and wellness services/products through Blue365.

### PARTICIPATING PHYSICIANS

You have access to 7,000+ physicians and healthcare professionals.

### AFFILIATED HOSPITALS

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

### PHARMACIES AND PRESCRIPTIONS

Our network includes 45,000 participating pharmacies. Prescriptions filled up to 31-day supply. We offer a **closed formulary**.

### MEDICARE COVERAGE

Medicare-primary enrollees are required to enroll in Senior Blue HMO, our **Medicare Advantage Plan**. To qualify, you must enroll in Medicare Parts A & B and live in the service area.

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

### NYSHIP CODE NUMBER 069

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

### HIGHMARK BLUE SHIELD OF NORTHEASTERN NEW YORK

P.O. Box 15013, Albany, NY 12212

### FOR INFORMATION:

**Highmark Blue Shield of Northeastern New York:** 1-844-639-2440

**TTY:** 711

**Website:** [www.highmark.com/member/nyship-blueshieldnny](http://www.highmark.com/member/nyship-blueshieldnny)

| BENEFITS   | ENROLLEE COST   |
|--|---|
| <b>Office Visits</b>   | \$25 per visit  |
| Annual Adult Routine Physicals   | No copayment  |
| Well Child Care  | No copayment  |
| <b>Specialty Office Visits</b>   | \$40 per visit  |
| <b>Diagnostic/Therapeutic Services</b>                                   |   |
| Radiology  | \$40 per visit  |
| Lab Tests  | No copayment  |
| Pathology  | No copayment  |
| EKG/EEG  | No copayment  |
| Radiation  | \$25 per visit  |
| Chemotherapy   | \$25 per visit  |
| Dialysis   | No copayment  |
| <b>Women's Health Care/Reproductive Health</b>                           |   |
| Pap Tests  | No copayment  |
| Mammograms   | No copayment  |
| Prenatal Visits  | No copayment <sup>1</sup>                             |
| Postnatal Visits   | No copayment  |
| Bone Density Tests   | No copayment  |
| Breastfeeding Services and Equipment                                     | No copayment  |
| Must be obtained from a participating Durable Medical Equipment provider |   |
| External Mastectomy Prosthesis   | No copayment  |
| <b>Family Planning Services</b>  | \$25 PCP, \$40 specialist per visit                   |
| <b>Infertility Services</b>  | Applicable physician/facility copayment               |
| <b>Contraceptive Drugs<sup>2</sup></b>                                   | Applicable Rx copayment                               |
| <b>Contraceptive Devices<sup>2</sup></b>                                 | Applicable Rx copayment                               |
| <b>Inpatient Hospital Surgery</b>  |   |
| Physician  | \$200 copayment or 20% coinsurance, whichever is less |
| Facility   | No copayment  |

| BENEFITS  | ENROLLEE COST  |
|---|--|
| <b>Outpatient Surgery</b>   |  |
| Hospital  | \$40 physician copayment per visit                   |
| Physician's Office  | \$50 copayment or 20% coinsurance, whichever is less |
| Outpatient Surgery Facility   | \$50 per visit                                       |
| <b>Weight Loss/Bariatric Surgery</b>  | Applicable surgery copayment                         |
| <b>Emergency Department</b>   | \$100 per visit (waived if admitted within 23 hours) |
| <b>Urgent Care Facility</b>   | \$35 per visit                                       |
| <b>Ambulance</b>  | \$100 per trip                                       |
| <b>Telehealth</b>   |  |
| Virtual Care PCP/Specialist   | \$25/\$40 per visit                                  |
| MDLIVE <sup>®</sup>   | No copayment   |
| <b>Outpatient Mental Health</b>   |  |
| Individual, unlimited   | \$25 per visit                                       |
| Group, unlimited  | \$25 per visit                                       |
| <b>Inpatient Mental Health</b>  | No copayment unlimited                               |
| <b>Outpatient Drug/Alcohol Rehab</b>  | \$25 per visit unlimited                             |
| <b>Inpatient Drug/Alcohol Rehab</b>   | No copayment unlimited                               |
| <b>Durable Medical Equipment</b>  | 50% coinsurance                                      |
| <b>Prosthetics</b>  | 50% coinsurance                                      |
| <b>Orthotics</b>  | 50% coinsurance                                      |
| <b>Rehabilitative Care, Physical, Speech and Occupational Therapy</b>                           |  |
| Inpatient, 60 days max  | No copayment   |
| Outpatient Physical or Occupational Therapy, 30 visits max for all outpatient services combined | \$40 per visit                                       |
| Outpatient Speech Therapy, 30 visits max for all outpatient services combined                   | \$40 per visit                                       |
| <b>Diabetic Supplies</b>  | \$25 per item 30-day supply                          |
| <b>Insulin and Oral Agents</b>  | \$25 per item 30-day supply                          |

<sup>1</sup> Inpatient Maternity/Delivery services follow the same cost share as Inpatient Surgery.

<sup>2</sup> Generic oral contraceptives and certain OTC contraceptive devices covered in full in accordance with the Affordable Care Act.

## BENEFITS

## ENROLLEE COST

|  |  |
|--|--|
| <b>Diabetic Shoes</b><br>three pairs per year when medically necessary | 50% coinsurance  |
| <b>Hospice</b> , 210 days max  | No copayment   |
| <b>Skilled Nursing Facility</b><br>45 days max per calendar year       | No copayment   |
| <b>Prescription Drugs</b>  |  |
| Retail, 30-day supply  | \$10 Tier 1,<br>\$30 Tier 2, \$50 Tier 3 <sup>3</sup>  |
| Mail Order, 90-day supply  | \$20 Tier 1,<br>\$60 Tier 2, \$100 Tier 3 <sup>3</sup> |

### Specialty Drugs

Specialty medications after the initial first fill must be purchased from one of our participating specialty pharmacies. A current list of specialty medications and pharmacies is available on our website.

## ADDITIONAL BENEFITS

### Annual Out-of-Pocket Maximum

(In-Network Benefits).....\$6,350 Individual,  
\$12,700 Family per year

**Dental**<sup>4</sup>.....\$40 per visit  
for injury to sound and natural teeth

**Vision**<sup>5</sup>.....\$40 per visit  
one routine exam every two years. Children to  
age 19 are covered every year.

**Eyewear**.....\$60 reimbursement  
once every two calendar years. Children to age 19:  
50% coinsurance, one pair per calendar year.

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

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

**Out of Area**.....The BlueCard and  
Away From Home Care Programs provide routine  
and urgent care coverage while traveling, for  
students away at college and families living apart.

## PLAN HIGHLIGHTS FOR 2024

Earn \$500 per family (\$250 employee and  
\$250 spouse/domestic partner) in dividend dollars  
each year for performing healthy activities through  
our online incentive program.

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

<sup>4</sup> Coverage for accidental injury to sound and natural teeth and for care due to congenital disease or anomaly; routine care not covered.

<sup>5</sup> Unlimited visits allowed for exams to treat a disease or injury of the eye.

## PARTICIPATING PHYSICIANS

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

## AFFILIATED HOSPITALS

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

## PHARMACIES AND PRESCRIPTIONS

Fill prescriptions at any of our more than 60,000 participating pharmacies nationwide. HMOBlue offers convenient mail-order services for select maintenance drugs. We offer a **closed formulary**.

## MEDICARE COVERAGE

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

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

### NYSHIP CODE NUMBER 072

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

### NYSHIP CODE NUMBER 160

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

## EXCELLUS BLUECROSS BLUESHIELD

### HMOBlue 072/HMOBlue 160

333 Butternut Drive, Syracuse, NY 13214-1803

### FOR INFORMATION:

**HMOBlue Customer Service:** 1-800-499-1275

**TTY:** 1-800-662-1220

**Website:** [www.excellusbcbs.com](http://www.excellusbcbs.com)



| BENEFITS                                       | ENROLLEE COST                                  |
|--|--|
| <b>Office Visits</b>                           |  |
| Adult (19+)                                    | \$10 per visit                                 |
| Child (0–18)                                   | No copayment                                   |
| Annual Adult Routine Physicals                 | No copayment                                   |
| Well Child Care                                | No copayment                                   |
| <b>Specialty Office Visits</b>                 | \$20 per visit                                 |
| <b>Diagnostic/Therapeutic Services</b>         |  |
| Radiology                                      |  |
| Adult (19+)                                    | \$20 Specialist per visit <sup>1</sup>         |
| Child (0–18)                                   | \$0 PCP/\$20 Specialist per visit <sup>1</sup> |
| Lab Tests                                      | No copayment                                   |
| Pathology                                      | No copayment                                   |
| EKG/EEG  |  |
| Adult (19+)                                    | \$10 PCP/\$20 Specialist per visit             |
| Child (0–18)                                   | \$0 PCP/\$20 Specialist per visit              |
| Radiation                                      | \$20 copayment per visit <sup>1</sup>          |
| Chemotherapy                                   |  |
| Adult (19+)                                    | \$10 PCP/\$20 Specialist per visit             |
| Child (0–18)                                   | \$0 PCP/\$20 Specialist per visit              |
| Dialysis                                       | \$20 copayment per visit                       |
| <b>Women’s Health Care/Reproductive Health</b> |  |
| Pap Tests                                      | No copayment                                   |
| Mammograms                                     | No copayment                                   |
| Prenatal Visits                                | No copayment                                   |
| Postnatal Visits                               | No copayment                                   |
| Bone Density Tests                             | No copayment                                   |
| Breastfeeding Services and Equipment           | No copayment                                   |
| External Mastectomy Prosthesis                 | 20% coinsurance unlimited                      |
| <b>Family Planning Services</b>                | \$20 per visit <sup>2</sup>                    |
| <b>Infertility Services</b>                    |  |
| Office   | \$20 per visit                                 |
| Outpatient Surgery Facility                    | \$100 per visit                                |
| <b>Contraceptive Drugs</b>                     | No copayment                                   |
| <b>Contraceptive Devices</b>                   | No copayment                                   |

<sup>1</sup> Hospital based: \$40 copayment per visit.

<sup>2</sup> Only preventive family planning services are covered in full. Non-preventive services require a copayment.

| BENEFITS   | ENROLLEE COST                         |
|--|---------------------------------------|
| <b>Inpatient Hospital Surgery</b>  | No copayment                          |
| <b>Outpatient Surgery</b>  |                                       |
| Hospital   | \$100 per visit                       |
| Physician’s Office   |                                       |
| Adult (19+)  | \$10 PCP/\$20 Specialist per visit    |
| Child (0–18)   | \$0 PCP/\$20 Specialist per visit     |
| Outpatient Surgery Facility  | \$100 per visit                       |
| <b>Weight Loss/Bariatric Surgery<sup>3</sup></b>   |                                       |
| Inpatient  | No copayment                          |
| Outpatient   | \$100 copayment                       |
| <b>Emergency Department</b><br>(waived if admitted)  | \$100 per visit                       |
| <b>Urgent Care Facility</b>  | \$35 per visit <sup>4</sup>           |
| <b>Ambulance</b>   | \$100 per trip                        |
| <b>Telehealth</b>  |                                       |
| Virtual Care PCP/Specialist  | \$0/\$20 per visit                    |
| Virtual Behavioral Health  | No copayment                          |
| <b>Outpatient Mental Health</b>  | \$10 per visit <sup>4</sup> unlimited |
| <b>Inpatient Mental Health</b>   | No copayment unlimited                |
| <b>Outpatient Drug/Alcohol Rehab</b>   | \$10 per visit <sup>4</sup> unlimited |
| <b>Inpatient Drug/Alcohol Rehab</b>  | No copayment unlimited                |
| <b>Durable Medical Equipment</b>   | 50% coinsurance                       |
| <b>Prosthetics</b>   | 20% coinsurance                       |
| <b>Orthotics</b>   | No copayment                          |
| <b>Rehabilitative Care, Physical, Speech and Occupational Therapy</b>                                    |                                       |
| Inpatient, 45 days max   | No copayment                          |
| Outpatient Physical or Occupational Therapy, 20 visits max per year for all outpatient services combined | \$20 per visit                        |
| Outpatient Speech Therapy, 20 visits max per year for all outpatient services combined                   | \$20 per visit                        |

<sup>3</sup> Preauthorization required.

<sup>4</sup> No copayment for children ages 0–18.

## BENEFITS

## ENROLLEE COST

### Diabetic Supplies

|            |              |
|------------|--------------|
| Retail     | No copayment |
| Mail Order | Not covered  |

### Insulin and Oral Agents

|            |  |
|------------|--|
| Retail     | \$10 or applicable Rx copayment, whichever is less |
| Mail Order | \$25 or applicable Rx copayment, whichever is less |

**Diabetic Shoes** No copayment

**Hospice, unlimited** No copayment

**Skilled Nursing Facility** No copayment  
45 days max

### Prescription Drugs

|  |   |
|--|---|
| Retail, 30-day supply <sup>5</sup>     | \$5 Tier 1,<br>\$30 Tier 2, \$60 Tier 3 <sup>6</sup>      |
| Mail Order, 90-day supply <sup>5</sup> | \$12.50 Tier 1,<br>\$75 Tier 2, \$150 Tier 3 <sup>6</sup> |

Coverage includes injectable and self-injectable medications, fertility drugs and enteral formulas.

### Specialty Drugs

Specialty drugs are provided by Reliance Rx Pharmacy and Walgreens, require prior approval and are subject to the applicable Rx copayment based on the formulary status of the medication.

## ADDITIONAL BENEFITS

### Annual Out-of-Pocket Maximum

(In-Network Benefits).....\$4,000 Individual,  
\$8,000 Family per year

**Dental**.....Discounts available and may vary by vendor.  
Please visit [www.independenthealth.com](http://www.independenthealth.com) for details.

**Vision**.....No copayment  
one routine visit every 12 months

**Eyeglasses**.....\$50 for single vision lenses;  
frames 40% off retail price

**Hearing Aids**.....Hearing aids  
from \$499 to \$2,199 each from Start Hearing.  
Contact plan for details.

**Out of Area**.....Coverage for urgent care  
and emergency situations only. Dependents are  
covered if they reside outside the service area  
for more than 90 days but less than 365 days.

**Wellness Services**.....\$600 Single/\$750 Family  
wellness card annual allowance for use at  
participating vendors. Funds do not roll over.

<sup>5</sup> Preventive medications are covered in full, see formulary for details.

<sup>6</sup> Tier 1 drugs are \$0 for children ages 0–18.

## PLAN HIGHLIGHTS FOR 2024

Opioid treatment programs (partial hospitalization, intensive outpatient and medication assisted treatment) are covered in full. Earn up to \$30 in “RedShirt Rewards” by completing activities focused on improving your health and wellness and redeem them for gift cards.

### PARTICIPATING PHYSICIANS

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

### AFFILIATED HOSPITALS

All Western New York hospitals participate with Independent Health and members may be directed to other hospitals when medically necessary.

### PHARMACIES AND PRESCRIPTIONS

All retail pharmacies in Western New York participate. Members may obtain prescriptions out of the service area by using our National Pharmacy Network, which includes 58,000 pharmacies nationwide. We offer a **closed formulary**.

### MEDICARE COVERAGE

Medicare-primary NYSHIP retirees must enroll in Medicare Encompass, a **Medicare Advantage Plan**. Copayments differ from the copayments of a NYSHIP-primary enrollee. To qualify, you must be enrolled in Medicare Parts A and B and live in the service area. Call our Member Services Department for detailed information.

**Important Note:** Only participating providers in the counties listed below are part of this HMO’s network within NYSHIP. Please be sure to check before receiving care that your provider participates with this HMO’s NYSHIP network.

### NYSHIP CODE NUMBER 059

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

### INDEPENDENT HEALTH

511 Farber Lakes Drive, Buffalo, NY 14221

### FOR INFORMATION:

**Customer Service:** 1-800-501-3439

**TTY:** 716-631-3108

**Website:** [www.independenthealth.com](http://www.independenthealth.com)



| BENEFITS  | ENROLLEE COST  |
|---|--|
| <b>Office Visits</b>                              | \$0 copayment  |
| Annual Adult Routine Physicals                    | No copayment   |
| Well Child Care                                   | No copayment   |
| <b>Specialty Office Visits</b>                    | \$25 per visit   |
| <b>Diagnostic/Therapeutic Services</b>            |  |
| Radiology   | \$15/\$25 per visit <sup>1,2</sup>                         |
| Lab Tests   | No copayment   |
| Pathology   | No copayment   |
| EKG/EEG   | \$25 per visit   |
| Radiation   | \$25 per visit   |
| Chemotherapy                                      | \$15/\$25 per visit <sup>2</sup>                           |
| Dialysis  | \$15/\$25 per visit <sup>2</sup>                           |
| <b>Women's Health Care/Reproductive Health</b>    |  |
| Pap Tests   | No copayment   |
| Mammograms  | No copayment   |
| Prenatal Visits                                   | No copayment   |
| Postnatal Visits                                  | No copayment   |
| Bone Density Tests                                | No copayment   |
| Breastfeeding Services and Equipment <sup>3</sup> | No copayment   |
| External Mastectomy Prosthesis <sup>4</sup>       | 50% coinsurance  |
| <b>Family Planning Services<sup>3</sup></b>       | \$25 per visit   |
| <b>Infertility Services<sup>3</sup></b>           | \$25 per visit   |
| <b>Contraceptive Drugs<sup>5</sup></b>            | No copayment   |
| <b>Contraceptive Devices<sup>5</sup></b>          | No copayment   |
| <b>Inpatient Hospital Surgery</b>                 | No copayment   |
| <b>Outpatient Surgery</b>                         |  |
| Hospital  | \$25 per visit   |
| Physician's Office                                | \$25 per visit   |
| Outpatient Surgery Facility                       | \$25 per visit <sup>1</sup>                                |
| <b>Weight Loss/Bariatric Surgery</b>              | No copayment at a Center of Excellence with prior approval |

| BENEFITS   | ENROLLEE COST                    |
|--|----------------------------------|
| <b>Emergency Department</b><br>(waived if admitted)                    | \$75 per visit                   |
| <b>Urgent Care Facility</b>  | \$15 per visit                   |
| <b>Ambulance</b>   | \$50 per trip                    |
| <b>Telehealth</b>  |                                  |
| Virtual Care PCP/Specialist  | No copayment/<br>\$25 per visit  |
| Gia® Virtual Care  | No copayment                     |
| <b>Outpatient Mental Health</b><br>unlimited                           | No copayment                     |
| <b>Inpatient Mental Health</b><br>unlimited                            | No copayment                     |
| <b>Outpatient Drug/Alcohol Rehab<sup>3</sup></b><br>unlimited          | No copayment                     |
| <b>Inpatient Drug/Alcohol Rehab<sup>3</sup></b><br>unlimited           | No copayment                     |
| <b>Durable Medical Equipment</b>                                       | 50% coinsurance                  |
| <b>Prosthetics</b>   | 50% coinsurance                  |
| <b>Orthotics</b>   | 50% coinsurance                  |
| <b>Rehabilitative Care, Physical, Speech and Occupational Therapy</b>  |                                  |
| Inpatient,<br>60 days max combined                                     | No copayment                     |
| Outpatient Physical or Occupational Therapy,<br>30 visits max combined | \$15/\$25 per visit <sup>2</sup> |
| Outpatient Speech Therapy,<br>30 visits max combined                   | \$15/\$25 per visit <sup>2</sup> |
| <b>Diabetic Supplies<sup>3</sup></b><br>30-day supply                  | No copayment                     |
| <b>Insulin and Oral Agents<sup>3</sup></b><br>30-day supply            | No copayment                     |
| <b>Diabetic Shoes</b>  | 50% coinsurance                  |
| <b>Hospice, 210 days max</b>   | No copayment                     |

<sup>1</sup> \$0 copayment when you use MVP preferred providers.

<sup>2</sup> \$15 PCP copayment/\$25 Specialist copayment.

<sup>3</sup> Refer to the Certificate of Coverage for requirements.

<sup>4</sup> Contact MVP for additional information regarding prior authorizations, quantity limits, participating providers, etc.

<sup>5</sup> Over-the-counter contraceptives are not covered.



## BENEFITS

## ENROLLEE COST

**Skilled Nursing Facility** No copayment  
45 days max per calendar year

### Prescription Drugs

Retail, 30-day supply \$0 Tier 1,  
\$30 Tier 2, \$50 Tier 3

Mail Order, up to 90-day supply \$0 Tier 1,  
\$75 Tier 2, \$125 Tier 3

If a brand-name drug is requested over the generic equivalent, you pay the difference between the cost of the two. This includes fertility drugs, prescribed contraceptives, injectables and enteral formulas. Approved generic contraceptive drugs, devices and those without a generic equivalent are covered at 100% under retail and mail order.

### Specialty Drugs

Retail covered as noted; 30-day supply limit. Prior authorization may be required. Thirty-day supply through Specialty Pharmacy. Members are required to use Caremark Specialty.

## ADDITIONAL BENEFITS

### Annual Out-of-Pocket Maximum

(In-Network Benefits).....\$6,350 Individual,  
\$12,700 Family per year

**Dental**.....\$25 per preventive visit  
once every 6 months (to age 19)

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

**Hearing Aids**.....Not covered

**Out of Area**.....Emergencies only

## PLAN HIGHLIGHTS FOR 2024

The Gia® by MVP mobile app gives you access to 24/7 virtual care services, including primary, urgent and emergency care. Get up to \$600 in Well-Being Reimbursements per contract per calendar year. \$0 primary care visits for all family members.

## PARTICIPATING PHYSICIANS

MVP provides services through 54,000 providers throughout its service area.

## AFFILIATED HOSPITALS

Find a participating facility at [mvphealthcare.com/findadoctor](http://mvphealthcare.com/findadoctor).

## PHARMACIES AND PRESCRIPTIONS

Thousands of participating pharmacies, including all major pharmacy chains. We offer a **closed formulary**.

## MEDICARE COVERAGE

Medicare-primary NYSHIP enrollees must enroll in MVP Preferred Gold, MVP's **Medicare Advantage Plan**. Some copayments may vary from the MVP HMO plan's copayments. To qualify, you must be enrolled in Medicare Parts A and B and live in the service area.

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

### NYSHIP CODE NUMBER 058

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

### NYSHIP CODE NUMBER 060

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

### NYSHIP CODE NUMBER 330

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

### NYSHIP CODE NUMBER 340

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

### NYSHIP CODE NUMBER 360

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

## MVP HEALTH CARE

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

## FOR INFORMATION:

**Customer Service:** 1-888-MVP-MBRS (687-6277)

**TTY:** 1-800-662-1220

**Website:** [www.mvphealthcare.com](http://www.mvphealthcare.com)

# NYSHIP ONLINE

NYSHIP Online is designed to provide you with targeted information about your NYSHIP benefits.

To log on, type [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) in your web browser and identify your Group and health insurance plan type (**Empire Plan** or **HMO**).

The screenshot shows the NYSHIP Online website. At the top is a teal header with the text "Department of Civil Service" and navigation links: "Online Services", "Job Seekers", "State Employees", "Retirees", "HR Professionals", and "About Us". Below this is a dark blue navigation bar with "Your Group • Your Plan" on the left and "Change Your Group" and "Search" on the right. The main content area features the "nyshiponline" logo (Employee Benefits Division, Department of Civil Service) and a "Current Topics" menu with the following items: "What's New", "Health Benefits & Option Transfer" (highlighted in red), "Dental & Vision Benefits", "Using Your Benefits", "Forms", "Planning to Retire?", "Find a Provider", "Calendar", "Resources", and "MyNYSHIP - Employee Self-Service". To the right of the menu is a photograph of a man with glasses and a beard, wearing a blue plaid shirt, sitting at a desk and looking at a laptop. At the bottom of the page is a light gray footer with links: "Civil Service Home", "Site Map", "HIPAA Privacy Information", "About Us", "Awards", "Tech Help", "Notices", and "Copyright/Disclaimer".

Click the tabs on the left side of the page to navigate to the information you are seeking.

**Health Benefits & Option Transfer** is where you will find rates and health plan choices, your *NYSHIP General Information Book* and links to forms and publications.

Links to helpful telephone numbers and websites, additional publications and forms and (for Empire Plan enrollees) expanded drug formulary information can be found under **Using Your Benefits**.

The frequently updated **What's New** section includes timely NYSHIP information based on your plan and is searchable by topic.

Also available on NYSHIP Online: resources to assist you in planning for retirement and access to MyNYSHIP,\* the enrollee self-service portal.

\* MyNYSHIP is not available to active employees of Participating Employers. You must be an active employee of a New York State agency and have a personal NY.gov ID to access MyNYSHIP.

## OPTION TRANSFER GUIDE

NYSHIP's Option Transfer Guide, available on NYSHIP Online, provides quick access to option transfer-related information and instructions, as well as tools and additional resources to assist you in your research. To access it, type [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits) in your web browser.

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**nyshiponline**

Civil Service Home NYSHIP Online Home

## 2024 Option Transfer Guide

Are you an active NYSHIP enrollee who is thinking about changing your health plan in 2024? Or a new employee interested in learning more about the annual Option Transfer Period? Either way, this guide has you covered!

### Active Employees

Welcome to NYSHIP Online, where you will find information on the New York State Health Insurance Program for State and Local Government for active employees. If you are a retiree, please visit NYSHIP Online for Retirees. In order to provide you with targeted information about your benefits, you will need to select your group (negotiating unit) and health insurance plan when prompted. If you are a New York State Active Employee and unsure of your group, our **Enrollee Group Wizard** will ask you a series of questions in order to determine which group you should select.

**This site uses cookies.** You have to have cookies enabled so that you will only need to access this page and select your group once. The site will remember your group for future visits. You will have the option of changing your group at any time after the initial log on.

To get started, you **MUST** select one of the following:

- I am a New York State Active Employee (NY)
- I am working for a Participating Employer (PE)
- I work for a Participating Agency (PA)
- I am a Graduate Student Enrolled in the Student Employee Health Plan (SEHP)
- I am not sure

[Continue](#)

### Are you considering changing your NYSHIP health insurance option in 2024?

Click here for quick access to information and tools to help you prepare for the upcoming Option Transfer Period.

**Disclaimer:**  
Please note that these materials do not apply to employees enrolled in NYSHIP through a Participating Agency (PA) or to graduate student employees in the Student Employee Health Plan (SEHP).

[Continue](#)

### If you decide to change your NYSHIP option

Complete the form(s) that correspond with your selection and submit to your Health Benefits Administrator by the Option Transfer deadline.

(Note: If you wish to enroll in the Opt-out Program, you must complete both forms.)

- [Health Insurance Transaction Form \(PS-404\)](#)  
Use to submit your option transfer request.
- [Opt-out Program Attestation Form \(PS-409\)](#)  
Use to enroll in the Opt-out Program.

### Additional Resources if you have questions

If you are in need of additional details, contact the health plan(s) directly or refer to NYSHIP's print publications.

- [Empire Plan Contact Information](#)  
Phone numbers, mailing addresses and web links.
- [HMO Contact Information](#)  
Phone numbers, mailing addresses and web links.
- [Health Insurance Choices for 2024](#)  
A printable PDF of the *Choices* book.

### Making a Choice

A list of things to consider as you review your health plan options.

### Plan Comparison Tool

Generate a side-by-side comparison of benefits provided by NYSHIP plans available in your area.

### Cost of Coverage

The amount you will pay for your NYSHIP health plan.

### Pre-Tax Contribution Program

Lower your taxable income by deducting your NYSHIP premium from your paycheck before taxes are withheld.

### Productivity Enhancement Program

If eligible for this program, you can exchange previously accrued annual or personal leave for a credit to be applied toward your NYSHIP premium.

This web page makes it easy to compare health benefits and costs, access PDF versions of current Option Transfer publications and download forms with just a few quick clicks. The Option Transfer Guide also includes links to information about a few other programs that are available for eligible NYSHIP enrollees to consider, including the Opt-out Program, the Pre-Tax Contribution Program and the Productivity Enhancement Program.

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

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

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**NYSHIP**  
New York State  
Health Insurance Program

## 2024 Health Insurance Choices (Active) – October 2023

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It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on NYSHIP Online at [www.cs.ny.gov/employee-benefits](http://www.cs.ny.gov/employee-benefits). Visit NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS agency websites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator. COBRA and Young Adult Option enrollees, contact the Employee Benefits Division.

Health Insurance Choices was printed using recycled paper and environmentally sensitive inks.  Choices 2024/Active  AL1998