



## New York State Health Insurance Program

### *Student Employee Health Plan (SEHP) for Graduate Student Employees*

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**January 1, 2009**

**For Graduate Student Employees  
and for their enrolled Dependents  
and for COBRA enrollees with  
SEHP benefits**

This guide briefly describes the principal NYSHIP SEHP benefits. It is not a complete description and is subject to change.

If you have questions about eligibility, enrollment procedures or the cost of health insurance, contact the agency Health Benefits Administrator on your SUNY campus.

CUNY SEHP enrollees with questions may contact their Health Benefits Administrator at the CUNY University Benefits Office.

For more detailed benefit information call the insurance carriers at the numbers on this page.

State of New York  
Department of Civil Service  
Employee Benefits Division  
Albany, New York 12239  
web site: [www.cs.state.ny.us](http://www.cs.state.ny.us)

#### **Benefit Summary**

The NYSHIP Student Employee Health Plan (SEHP) is a health insurance program for CUNY and SUNY graduate and teaching assistant employees and their families. The plan provides medical, dental and vision care benefits.

#### **Call Toll Free 1-877-7-NYSHIP (1-877-769-7447)**

For pre-authorization of services or if you have a question about providers or claims, please call toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the carrier you need. UnitedHealthcare and Empire BlueCross BlueShield representatives are available Monday through Friday, 8:00 a.m. to 4:30 p.m. Eastern time. OptumHealth and Prescription Drug Program representatives are available 24 hours a day, seven days a week. This number is for both The Empire Plan (another NYSHIP plan) and NYSHIP SEHP (except for the NurseLine option, which is for The Empire Plan only). SEHP dental and vision care plans have separate toll-free numbers (see below).

#### **Hospital Benefits Program insured and administered by Empire BlueCross BlueShield\***

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

\* Services provided by Empire Healthchoice Assurance, Inc., an independent licensee of the BlueCross BlueShield Association.

#### **Medical/Surgical Benefits Program insured and administered by UnitedHealthcare**

Provides coverage for medical services, such as office visits, surgery and diagnostic testing under the network and non-network programs. Coverage for chiropractic care and physical therapy is provided through the Managed Physical Medicine Program. Home care services provided in lieu of hospitalization and diabetic supplies provided by the Home Care Advocacy Program (HCAP). Benefits Management Program services for Prospective Procedure Review of Magnetic Resonance Imaging (MRI).

#### **Managed Mental Health and Substance Abuse Program insured by UnitedHealthcare and administered by OptumHealth Behavioral Solutions**

Provides coverage for inpatient and outpatient mental health and outpatient substance abuse services.

#### **Prescription Drug Program insured by UnitedHealthcare and jointly administered by UnitedHealthcare and Medco Health Solutions**

Provides coverage for prescription drugs, oral contraceptives and diaphragms through network pharmacies, the Medco Mail Service pharmacy and non-network pharmacies.

#### **Dental Care Plan administered by GHI 1-800-947-0101**

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

#### **Vision Care Plan administered by EyeMed 1-877-226-1412**

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

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## SEHP Health Insurance Benefit Summary

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### Annual Benefit Maximums

Annual maximum for prescription drugs, network and non-network combined: \$2,500. The Annual Benefit Maximums for all other NYSHIP SEHP coverage, except prescription drugs:

Non-network benefits: \$100,000

All benefits (network and non-network combined): \$350,000

All services must be medically necessary. "Allowable expenses" or "allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carriers, whichever is lower.

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## Benefits Management Program

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**YOU MUST CALL**

### Pre-Admission Certification

If NYSHIP SEHP coverage is primary for you or your covered dependents:

You must call the Plan toll-free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire BlueCross BlueShield:

- Before a scheduled (non-emergency) hospital admission
- Before a maternity hospital admission
- Within 48 hours after an emergency or urgent hospital admission

If you do not call, or if Empire BlueCross BlueShield does not certify the hospitalization, the Plan pays up to 50 percent of allowable expenses after your \$200 copayment.



**YOU MUST CALL**

### Prior Authorization of Magnetic Resonance Imaging (MRI)

If NYSHIP SEHP coverage is primary for you or your covered dependents:

You must call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose UnitedHealthcare for prior authorization before having a scheduled (non-emergency) Magnetic Resonance Imaging (MRI), unless you are having the test as an inpatient in a hospital. If you do not call, you will pay a large part of the costs. If the MRI is determined to be not medically necessary, you will be responsible for the entire cost.

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## Inpatient and Outpatient Hospital Coverage

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### Empire BlueCross BlueShield

**New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407**

Empire BlueCross BlueShield pays for covered services provided in an inpatient or outpatient hospital setting. UnitedHealthcare provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by Empire BlueCross BlueShield. Call the Plan toll-free at 1-877-7-NYSHIP (1-877-769-7447) and choose Empire BlueCross BlueShield if you have questions about your hospital benefits, coverage or an Explanation of Benefits statement.

## Network Coverage

(or)

## Non-Network Coverage



**YOU MUST CALL for pre-admission certification**

Copayment: \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

Coverage level: The Plan pays 100 percent of allowable amount after you pay the copayment.

Unlimited days for covered medical or surgical care in a hospital, except inpatient detoxification which is limited to 7 days per person per year.

Maternity Care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or first 96 hours following a cesarean section are presumed medically necessary and covered at the same copayment and coverage level as other inpatient admissions. If you choose early discharge following delivery, you may request one paid-in-full home care visit.

### Hospital Inpatient • Semi-Private Room or Birthing Center

Copayment: \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

Coverage level: The Plan pays 80 percent of allowable amount after you pay the copayment. You are responsible for the balance.

Unlimited days for covered medical or surgical care in a hospital, except inpatient detoxification, which is limited to 7 days per person per year.

Same as network coverage.

### Hospital Outpatient

Surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital (or an extension clinic, including ambulatory surgical centers) are subject to one copayment of \$15 per visit. The copayment is waived if you are admitted as an inpatient directly from the outpatient department.

For Magnetic Resonance Imaging (MRI), you must have prior authorization (see page 2).

\$10 copayment per visit for up to 60 visits for medically necessary physical therapy following a related hospitalization or related inpatient or outpatient surgery.

Emergency Room services, including use of the facility for emergency care and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services are subject to one copayment of \$25 per visit. The copayment is waived if you are admitted as an inpatient directly from the emergency room.

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

Paid-in-full benefits for chemotherapy, radiation therapy or dialysis and for pre-admission testing and/or pre-surgical testing prior to an inpatient admission.

Outpatient Care: Same as network coverage, except subject to an annual deductible of \$100 per covered individual. (Not combined with physical therapy deductible.)

Coinsurance: The plan pays 80 percent of allowable expenses after you meet the \$100 deductible.

Non-network coverage subject to a separate \$100 deductible for all physical therapy. (Not combined with hospital outpatient deductible.)

Emergency Care: Same as network coverage.

Same as network coverage.

**Network Coverage**

(or)

**Non-Network Coverage**

**Infertility**

The following services provided in the inpatient or outpatient departments of a hospital are covered: artificial/intra-uterine insemination, inpatient and/or outpatient surgical or medical procedures, performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility, and associated diagnostic tests and procedures including but not limited to those described in New York State Insurance Law as set forth in Chapter 82 of the Laws of 2002.

Same as network coverage.

**Hospice Care**

Paid-in-full benefit for up to 210 days when provided by an approved hospice program.

Plan pays up to 100 percent of allowable expenses for up to 210 days.

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**Medical/Surgical Coverage**

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**UnitedHealthcare**

***P.O. Box 1600, Kingston, New York 12402-1600***

UnitedHealthcare benefits are paid under either the Network or Non-Network Coverage. Some medically necessary services are paid in full; others are subject to copayment or to a 15-visit per person limit. Note: Any visits you make to your SUNY Campus Student Health Center, which is not a network provider, do not count toward the 15-visit per person limit or network dollar maximum. (This does not apply to CUNY SEHP enrollees). Call the Plan toll-free at 1-877-7-NYSHIP (1-877-769-7447) and choose UnitedHealthcare if you have questions about your medical/surgical coverage.

**Network Coverage**

(or)

**Non-Network Coverage**

Some covered services received from a network provider are paid-in-full and others are subject to a copayment as described below.

The Plan does not guarantee that participating providers are available in all specialties or geographic locations.

To learn whether a provider participates, check with the provider directly, call UnitedHealthcare or visit the Department of Civil Service web site at [www.cs.state.ny.us](http://www.cs.state.ny.us). Click on Benefit Programs then NYSHIP Online, and choose your group, if prompted. Always confirm the provider's participation **before** you receive services.

**Annual Deductible:** \$100 per covered individual.

**Coinsurance:** Plan pays 80 percent of allowable expenses for covered services after you meet the annual deductible.

**Inpatient in a Hospital or Birthing Center**

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

Paid-in-full benefit for pre-admission testing and/or pre-surgical testing prior to an inpatient admission, radiology, anesthesiology and pathology.

Non-network benefits for covered services by a non-network provider.

Same as network coverage.

## Network Coverage

(or)

## Non-Network Coverage

### Outpatient Department of a Hospital

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

For medical emergency: paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services when these services are not covered by Empire BlueCross BlueShield. Services of other physicians are considered under network coverage or non-network coverage as appropriate.

Paid-in-full benefit for pre-admission testing and/or pre-surgical testing prior to an inpatient admission, chemotherapy, anesthesiology, radiology, pathology or dialysis when not covered by Empire BlueCross BlueShield; does not count toward 15-visit per person limit.

Medically necessary physical therapy covered under the Managed Physical Medicine Program when not covered by Empire BlueCross BlueShield.

Non-network benefits for covered services by a non-network provider.

Same as network coverage.

Plan pays up to 100 percent of allowable expenses.

Non-network coverage under the Managed Physical Medicine Program when not covered by Empire BlueCross BlueShield.

### Doctor's Office Visit, Office Surgery, Laboratory and Radiology

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

The following types of office visits and services are paid in full and do not count toward the 15-visit per person limit: hemodialysis, chemotherapy and radiation therapy, well-child care, prenatal and postnatal office visits included in your provider's delivery charge. Prenatal and postnatal office visits that are not included in the delivery charge are subject to a \$10 copayment but do not count toward 15-visit per person limit.

Diagnostic laboratory tests and radiology not performed during an office visit, including interpretation of mammograms and analysis of cervical cytology screening, are covered subject to a \$10 copayment and do not count toward the 15-visit per person limit.

\$10 copayment for contraceptive drugs and devices that require injection, insertion or other physician intervention and are provided during an office visit. (This copayment is in addition to your \$10 copayment for the office visit.)

Infertility treatment: \$10 copayment for covered services such as artificial/intra-uterine insemination (see page 4) provided during an office visit.

MRIs require prior authorization (see page 2).

Outpatient surgery visits are not subject to copayment but count toward 15-visit per person limit.

Second surgical opinion: \$10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; counts toward 15-visit per person limit. One paid-in-full in-hospital consultation in each field per confinement.

\$10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of course of treatment for cancer.

Non-network benefits for covered services received from non-participating providers or after the 15<sup>th</sup> visit to a participating provider.

Contraceptive drugs and devices: Same as network coverage, subject to deductible and coinsurance.

Infertility treatment: Same as network coverage, subject to deductible and coinsurance.

Second surgical opinion: Same as network coverage, subject to deductible and coinsurance.

Second opinion for cancer diagnosis: Same as network coverage.

**Medical/Surgical Coverage, continued on next page**

## Network Coverage

(or)

## Non-Network Coverage

### Routine Health Exams

Same as non-network coverage.

Routine physical: Up to \$60 reimbursement once every two years for active employee under age 40; annually for active employee over age 40. Not subject to copayment or 15-visit per person limit or deductible. There is no coverage for routine health exams for a spouse/domestic partner.

### Allergy Care

Office visits are covered subject to a \$10 copayment and count toward 15-visit per person limit. No separate copayment for basic skin tests done during office visit. Tests provided on different date or different location require a separate \$10 copayment, but do not count toward 15-visit per person limit.

Not Covered

### Routine Well-Child Care

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

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

### Mammograms and Cervical Cytology Screening

\$10 copayment for mammography received from a network provider following recommended guidelines. \$10 copayment for cervical cytology screening. (Also see Hospital Outpatient, page 3.)

Plan pays 80 percent of allowable expenses after you meet the annual deductible.

### Pregnancy Termination

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

Plan pays 80 percent of allowable expenses after you meet the annual deductible.

### Ambulatory Surgical Center

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

Non-network benefits for covered services provided by non-participating surgical centers.

### Ambulance Service

Plan pays for local commercial ambulance charges for emergency transportation, subject to a \$15 copayment.

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

**Non-emergency transportation** is covered the same as non-network coverage.

**Emergency transportation** is covered the same as network coverage. This benefit is not subject to deductible or coinsurance.

**Non-emergency transportation** is covered if it is medically necessary and provided by a licensed ambulance service. The Plan pays 80 percent of allowable expenses after you meet the annual deductible.

## Network Coverage

(or)

## Non-Network Coverage

### Enteral Formulas; Modified Solid Food Products

Same as non-network coverage.

For prescribed enteral formulas, Plan pays up to 80 percent after you meet the annual deductible. For certain prescribed modified solid food products, Plan pays up to 80 percent after you meet the annual deductible, up to a total maximum reimbursement of \$2,500 per covered person per calendar year.

## Managed Physical Medicine Program (MPN)

### (When you use MPN) Network Coverage

(or)

### (When you don't use MPN) Non-Network Coverage

#### Chiropractic Treatment and Physical Therapy

You pay a \$10 copayment for each office visit to a Managed Physical Network provider. You pay an additional \$10 copayment for related radiology and diagnostic laboratory services billed by the MPN provider.

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

Physical Therapy: Up to 60 visits per diagnosis, if determined by MPN to be medically necessary.

Access to network benefits is guaranteed for chiropractic treatment and physical therapy. If there is not a network provider in your area, call the Plan toll-free at 1-877-7-NYSHIP (1-877-769-7447) and choose UnitedHealthcare's MPN.

**Annual Deductible:** \$100 per covered individual. This deductible is separate from other plan deductibles.

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

Non-network benefits for covered services received from non-network providers, or after the 15<sup>th</sup> chiropractic visit per year, or after the 60<sup>th</sup> physical therapy visit per diagnosis, by a network provider.

Program requirements apply even if another health insurance plan (including Medicare) is primary.

## Home Care Advocacy Program (HCAP)

### (When you use HCAP) Network Coverage

(or)

### (When you don't use HCAP) Non-Network Coverage

#### Home Care Services in Lieu of Hospitalization and Diabetic Equipment/Supplies



**YOU MUST CALL for prior authorization**

Home care services provided in lieu of hospitalization are paid in full for 365 visits. To receive this benefit, you must call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose UnitedHealthcare's Home Care Advocacy Program (HCAP) for prior authorization.

Diabetic equipment and supplies, including insulin pumps and Medijectors are paid in full. To receive diabetic equipment and supplies, (except insulin pumps and Medijectors) call The Empire Plan Diabetic Supplies Pharmacy at 1-888-306-7337. For insulin pumps and Medijectors you must call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose UnitedHealthcare's HCAP for prior authorization and use a network provider.

Home care not covered unless pre-certified.

If pre-certified, Plan pays 80 percent of allowable expenses after you meet the annual deductible.

Diabetic equipment and supplies are covered up to 100 percent of allowable expenses; not subject to deductible and coinsurance.

Program requirements apply even if another health insurance plan (including Medicare) is primary.

# Mental Health and Substance Abuse Program



**YOU MUST CALL**

**OptumHealth Behavioral Solutions (administrator for UnitedHealthcare)**

**P.O. Box 5190, Kingston, NY 12402-5190**

Pre-certification required. Call the plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth (administrator for UnitedHealthcare) before seeking any treatment for mental health or substance abuse, including alcoholism. OptumHealth's Clinical Referral Line is available 24 hours a day, every day of the year. By following the Program requirements for network coverage, you will receive the highest level of benefits. Access to network benefits is guaranteed.

In an emergency, OptumHealth will either arrange for an appropriate provider to call you back (usually within 30 minutes) or direct you to an appropriate facility for treatment. In a life-threatening situation, go to the emergency room. If you are admitted as an inpatient, you or someone acting on your behalf should call OptumHealth within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

**Program requirements apply even if another health insurance plan (including Medicare) is primary.**

Only treatment determined medically necessary by OptumHealth is covered.

*If you are in treatment for mental health or alcohol/substance abuse at the time your NYSHIP SEHP coverage begins, please contact OptumHealth for help in making the transition to your NYSHIP coverage.*

## Network Coverage

(or)

## Non-Network Coverage

### Mental Health Facility

**Mental Health Care in an Approved General Acute or Psychiatric Hospital or Clinic: Inpatient and Partial Hospitalization, Intensive Outpatient and Day Treatment Programs, 23 Hour Extended and 72 Hour Crisis Beds.**  
Copayment: \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays up to 100 percent (50 percent if elective care is not pre-certified) of the network allowance after you pay the copayment.

**Mental Health Care in a Residential Treatment Center, Group Home or Halfway House.** Coverage for up to 30 days per person per year in an approved facility. \$200 copayment per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: Plan pays up to 80 percent (50 percent if elective care is not pre-certified) of the network allowance after the copayment. You pay the remaining balance.

**Mental Health Care in an Approved General Acute or Psychiatric Hospital or Clinic: Inpatient and Partial Hospitalization, Intensive Outpatient and Day Treatment Programs, 23 Hour Extended and 72 Hour Crisis Beds.**

Copayment: \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays 80 percent (50 percent if elective care is not pre-certified) of OptumHealth's reasonable and customary amount after you pay the copayment. You pay the remaining balance.

**Mental Health Care in a Residential Treatment Center, Group Home or Halfway House.** Not a covered benefit.

### Inpatient Alcohol/Substance Abuse

The Plan covers up to seven days for detoxification under the hospital benefit (see page 3). No coverage for inpatient alcohol/substance abuse treatment.

Same as network benefits.

### Outpatient Mental Health

Network coverage for up to 15 visits per person per calendar year to a network practitioner, subject to a \$10 copayment per visit. You pay the copayment. For visits 16 and beyond, non-network outpatient coverage applies.

Non-network benefits for covered services received from non-network practitioners or after the 15<sup>th</sup> visit to a network practitioner. Annual Deductible: \$100 per covered individual: Plan pays 80 percent of OptumHealth's reasonable and customary amount for covered services after the deductible. You pay the deductible and the remaining balance. The annual deductible is separate from the medical deductible.

Hospital emergency room: You pay a \$25 copayment (waived if you are admitted as an inpatient directly from the emergency room.)

Hospital emergency room: Same as network benefits.

## Network Coverage

(or)

## Non-Network Coverage

### Outpatient Alcohol/Substance Abuse

100 percent of allowable expenses, less your \$10 copayment per visit for medically necessary pre-certified care (20 visits annually available for family members). When multiple visits per week are pre-certified, only two copayments will apply.

Plan pays 100 percent of allowable expenses, less your \$10 copayment, for non-network visits. Coverage for up to 60 visits annually (20 of which can be used by family members).

If not pre-certified, Plan pays 50 percent of allowable expenses, less your \$10 copayment.

## Prescription Drug Program

Jointly administered by UnitedHealthcare and Medco Health Solutions

The Empire Plan Prescription Drug Program, P.O. Box 5900, Kingston, New York 12402-5900

### Benefit Maximum

\$2,500 per person annual maximum for prescription drugs (network and non-network combined)

### Copayments

You have the following copayments for drugs purchased from a participating pharmacy or through the Mail Service pharmacy.

Up to a 30-day supply from a participating retail pharmacy or through the Mail Service

Generic Drug.....	\$5
Preferred Brand-Name Drug.....	\$15
Non-Preferred Brand-Name Drug .....	\$30

31- to 90-day supply only through the Mail Service

Generic Drug.....	\$5
Preferred Brand-Name Drug.....	\$20
Non-Preferred Brand-Name Drug .....	\$55

If you choose to purchase a brand-name drug that has a generic equivalent, you will pay the non-preferred brand-name drug copayment plus the difference in cost between the brand-name drug and the generic, not to exceed the full cost of the drug. Certain drugs are excluded from this requirement. You pay only the applicable copayment for these brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid and Tegretol. You have coverage for prescriptions for more than a 30-day supply only at the mail service pharmacy. Oral contraceptives are covered as brand or generic. Prescriptions may be refilled for up to one year.

### Preferred Drug List

See your agency Health Benefits Administrator (HBA) or visit our web site for a copy of the 2009 Empire Plan Preferred Drug List (PDL), which applies to your Plan. It is not a complete list of all drugs covered under the SEHP but represents the most commonly prescribed generic and brand-name drugs. The PDL offers alternatives that are safe and effective equivalents to higher cost drugs. Medically necessary non-preferred brand-name drugs that are not on the PDL are covered, but at a higher cost to you and subject to the annual maximum.

Alphabetic order and therapeutic class order versions of the 2009 PDL are both available on the web site at [www.cs.state.ny.us](http://www.cs.state.ny.us). Click on Benefit Programs, then NYSHIP Online and choose SEHP, if prompted. The lists are available under Health Benefits.

### Mail Service Pharmacy

You may fill your prescription through the mail service by using a mail order form. To obtain a mail order form, call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Prescription Drug Program, or download a copy from the New York State Department of Civil Service web site at [www.cs.state.ny.us](http://www.cs.state.ny.us). Click on Benefit Programs then NYSHIP Online, and choose your group, if prompted. Prescription refills may be ordered by phone at the above number, or online by accessing the NYSHIP Online web site as directed above, selecting Find a Provider and scrolling down to the Empire Plan Prescription Drug Program web site link.

### Non-Network Pharmacy

If you do not use an Empire Plan network pharmacy, you must submit a claim to the Prescription Drug Program. If your prescription was filled with a generic drug or a brand-name drug with no generic equivalent, you will be reimbursed up to the amount the program would reimburse a network pharmacy for that prescription. If your prescription was filled with a brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the program would reimburse a network pharmacy for filling the prescription with that drug's generic equivalent. In most cases, you will not be reimbursed the total amount you paid for the prescription.

Prescription Drug Program, continued on next page

## Prior Authorization Required

Certain prescription drugs require prior authorization:

Amevive, Aranesp, Avonex, Betaseron, Botox, Cimzia, Copaxone, Enbrel, Epogen/Procrit, Flolan, Forteo, Growth Hormones, Humira, Immune Globulins, Increlex, Infergen, Intron-A, Iplex, Kineret, Kuvan, Lamisil, Letairis, Myobloc, Orencia, Pegasys, Peg-Intron, Provigil, Raptiva, Rebif, Remicade, Remodulin, Revatio, Sporanox, Synagis, Tracleer, Tysabri, Ventavis, Xolair. This list is subject to change. For the most current list of drugs requiring prior authorization, call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Prescription Drug Program or check the web at [www.cs.state.ny.us](http://www.cs.state.ny.us) (choose Benefit Programs then NYSHIP Online, and choose your group, if prompted). For information about prior authorization requirements, call the Prescription Drug Program at the number above.

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

## Exclusions

Services not covered under the SEHP include, but are not limited to, the following:

- expenses in excess of \$100,000 (non-network benefits); in excess of \$350,000 (network and non-network combined); and prescription drugs in excess of \$2,500 (network and non-network combined);
- care that is not medically necessary;
- experimental or investigative procedures;
- custodial care;
- cosmetic surgery;
- routine foot care;
- sex change;
- reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intra-uterine insemination and other services for which coverage is mandated by New York State Insurance Law); cloning;
- durable medical equipment and supplies unless provided under the Home Care benefit;
- prosthetics (except breast prostheses, which are paid in full);
- orthotics;
- TMJ treatment (except when caused by a medical condition);
- hearing aids;
- weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity);
- adult immunizations (except as part of a covered routine physical);
- skilled nursing facility care;
- allergy extracts and injections;
- inpatient alcohol and substance abuse treatment (except detoxification is covered for up to 7 days);
- psychological testing and evaluation and outpatient psychiatric second opinion;
- drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease.

## SEHP Dental Care Benefit Summary

### Dental Program

Each visit is subject to a \$20 copayment, up to two visits per 12-month period when you visit a participating provider in the SEHP dental program for covered services.

#### Covered Services

- Initial examination, including charting
- Periodic examination
- Cleaning
- Bitewing X-Rays, maximum four X-rays per year

Up to two fillings per 12-month period are covered subject to a \$10 copayment per filling when you visit a participating provider in the SEHP dental program.

**Participating Provider:** To locate a participating provider in the SEHP dental program, you can link to the GHI web site by accessing [www.cs.state.ny.us](http://www.cs.state.ny.us). Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. Select Other Benefits, then Dental or call 1-800-947-0101.

## GHI's Discounted Dental Access Program

When you enroll in the SEHP dental program you are automatically enrolled in GHI's Discounted Dental Access Program. If you utilize a provider who participates in the GHI Discounted Dental Access Program (and receive services other than the covered services above), you are required to pay the provider directly for all care received, and your liability is reduced to a pre-arranged discounted access rate. You are not subject to precertification or eligibility verification when you utilize the discounted program.

**Participating Provider:** To locate a participating provider in the GHI Discounted Dental Access Program, please call GHI's Dedicated Customer Service Center at 1-800-947-0101 for a list or a CD-ROM identifying GHI Discounted Dental Access Program participating providers.

## Administration

For **Eligibility** questions, please contact the agency Health Benefits Administrator on your campus.

For **Customer Service**, please contact GHI's Dedicated Customer Services Center at 1-800-947-0101 after you have enrolled.

**Correspondence:** Please direct your correspondence to:

GHI, Attn: NYS Dental Customer Service, P.O. Box 12365, Albany, New York 12212-2365.

Please be sure to include your identification number on all correspondence.

**ID Card:** If you go to a provider who participates in the SEHP dental program and/or the GHI Discounted Dental Access Program, present your GHI identification card before you receive services.

## SEHP Vision Care Benefit Summary

### Network Benefits

A routine eye examination (subject to a \$10 copayment) is covered once in any 24-month period (based on your last date of service).

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

### To confirm eligibility or locate a network provider

Contact EyeMed, the plan administrator, at 1-877-226-1412 or link to their web site by accessing [www.cs.state.ny.us](http://www.cs.state.ny.us). Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. Select Other Benefits, then Vision.

### To receive services from a network provider

- Contact the network provider and schedule an appointment.
- Identify yourself as covered under the SEHP vision care program available through the NYS Vision Plan, which is administered by EyeMed.
- Give the provider your name and date of birth, or member ID number.

The provider will confirm your eligibility and obtain an authorization to provide services. At the time of your appointment, be sure to pay the provider your \$10 eye examination copayment.



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

SEHP Benefit Summary - January 2009

**Please do not send mail  
or correspondence to the  
return address listed above.  
See address below.**

It is the policy of the State of New York 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 the Department of Civil Service web site (www.cs.state.ny.us). Click on Benefit Programs then NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS agency web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

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### Notice of Access to Women's Health Services

This notice is provided in accordance with the NYS Women's Health and Wellness Act. Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. Plan covers services required as a result of such examinations. Plan covers services required as a result of an acute gynecologic condition. Plan covers all care related to pregnancy. Benefits for these services are paid according to the terms of Network or Non-Network coverage.

*Benefits Management Program requirements apply. See page 2.*

### Annual Notice of Mastectomy and Reconstructive Surgery Benefits

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

*Benefits Management Program requirements apply. See page 2.*

### Teletypewriter (TTY) numbers for callers who use a TTY because of a hearing or speech disability

Empire BlueCross BlueShield.....	TTY Only 1-800-241-6894
UnitedHealthcare .....	TTY Only 1-888-697-9054
OptumHealth .....	TTY Only 1-800-855-2881
The Prescription Drug Program.....	TTY Only 1-800-855-2881
EyeMed .....	TTY Only 1-866-308-5375

*This document provides a brief look at SEHP medical, dental and vision care benefits. If you have questions or need claim forms, call the appropriate insurance carrier.*

The NYSHIP SEHP Benefit Summary is published by the Employee Benefits Division of the State of New York Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits.



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