SUMMARY OF BENEFITS

2026

A SIDE-BY-SIDE COMPARISON OF THE EMPIRE PLAN AND MVP

Contents

PLAN COSTS

Premiums

The Empire Plan

Individual Plan: Monthly Premium
- Active Employee/Non-Medicare Retiree $1,611.46
- COBRA $1,643.69
- Medicare Retired Employee $596.38

Family Plan: Monthly Premium
- Active Employee/Non-Medicare Retired Employee $3,663.79
- COBRA $3,737.07
- Retired Employee with 1 Medicare enrollee $2,261.97
- Retired Employee with 2 or more Medicare enrollees $1,633.33

MVP

Individual Plan: Monthly Premium
- Active Employee/Retiree $1,487.74
- COBRA $1,517.49

Employee & Spouse: Monthly Premium
- Active Employee/Retiree $3,421.81
- COBRA $3,490.25

Employee & Child(ren): Monthly Premium
- Active Employee/Retiree $2,826.71
- COBRA $2,883.24

Family: Monthly Premium
- Active Employee/Retiree $3,793.75
- COBRA $3,869.63

Contributions

Active Employees

	0-12 years of service	13-15 years of service	Beginning of 16th Year	
CSEA Hired 1/1/08 and after	17%	15%	10%	
	0-11 Years of Service	**12-14 Years of Service**	**Beginning of 15th Year**	
PCSEA Hired 12/5/07 and after	17%	15%	10%	
	0-4 years of Service	**5-8 years of service**	**9-12 Years of Service**	**Beginning of 13th Year**
PBA	17%	15%	5%	0%
PUMA/MGMT Hired 4/1/06 and after	17%			

Retiree

Annual Amount of Pension Benefit	Amount of Premium Payable by retiree
$65,000 and higher	30%
$52,500-$64,999	25%
$40,000-$52,499	21.5%
$30,000-$39,999	18%
$20,000-$29,999	13%
$10,000-$19,999	10%
$0-$9,999	8%

Dependent Survivor

Dependent Survivor pay 50% of the monthly premium.

Important Questions

What is the overall deductible?

EMPIRE PLAN: $1,250 per enrollee, per spouse/domestic partner, & per all dependent children combined. *The deductible only applies when you seek out-of-network services.* You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use that are not provided at a network facility or by a participating provider. The deductible renews each year.

MVP: $0. See the Common Medical Events below for your costs for services this plan covers.

Are the services covered before you meet your deductible?

EMPIRE PLAN: Yes. The deductible does not apply to care rendered at a network facility or by a participating provider, preventive care services as defined by the federal Patient Protection & Affordable Care Act (PPACA), hearing aids, prosthetic wigs, modified solid food products, second opinion for cancer diagnosis, external mastectomy prostheses, mastectomy bras, emergency services, emergency ambulance services, services under the Managed Physical Medicine Program, or prescription drugs. Most services rendered by a participating provider or at a network facility require only a copayment & doesn't count toward the Basic Medical Program deductible. The deductible only applies when you receive out-of-network services

MVP: Yes. Preventive care services are covered before you meet your deductible. This plan covers some items & services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.

Are there other deductibles for specific services?

EMPIRE PLAN: Yes. $250 per enrollee, per spouse/domestic partner, and per all dependent children combined for non-network Managed Physical Medicine Program. There are no other specific deductibles. You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

MVP: No. you don't have to meet deductibles for specific services.

What is the out-of-pocket limit for this plan?

EMPIRE PLAN: In-Network Max: Individual $4,244/Family $8,487.* Out-of-Network Coinsurance Max: $3,750 per enrollee, per spouse/domestic partner, & per all dependent children combined. *In-network Drug OOP Limit does not apply to Empire Plan Medicare Rx enrollees. The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

MVP: This plan does not have an out-of-pocket limit on your expenses. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

What isn't included in the out-of-pocket limit?

EMPIRE PLAN: Premiums, balance-billed charges & health care this plan does not cover doesn't count toward either out-of-pocket limit. In-Network Max excludes non-network expenses & ancillary charges. Out-of-Network Coinsurance Max excludes facility copayments, penalties, & expenses incurred under the Prescription Drug Program, Managed Physical Medicine Program services or Home Care Advocacy Program. Even though you pay these expenses, they don't count toward the out-of-pocket limit.

MVP: This plan does not have an out-of-pocket limit on your expenses

Will you pay less if you see a network provider?

EMPIRE PLAN: Yes. See www.cs.ny.gov/employee-benefits or call 1-877-7-NYSHIP & choose the appropriate program for a list of participating providers. If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out of network provider for some services. Plans use the terms in network, preferred, or participating for providers in their network. See the chart starting below for how this plan pays different kinds of providers.

MVP: Yes. See www.mvphealthcare.com or call 1-888-687-6277 for a list of network providers. This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, & you might receive a bill from a provider for the difference between the provider's charge & what your plan pays (balance billing). Be aware, your network provider might use an out of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?

EMPIRE PLAN: No. You don't need a referral to see a specialist. You can see the specialist you choose without permission from this plan.

MVP: No. You can see the specialist you choose without a referral.

COMMON MEDICAL EVENTS

If you visit a health care provider's office or clinic

EMPIRE PLAN:

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Primary care visit to treat an injury or illness	**$**25 co-payment/visit	20% coinsurance	None
Specialist visit	**$**25 co-payment/visit	20% coinsurance	None
Preventative care/screening/ immunization	No charge	Most services not covered	Certain services are covered when rendered by a non-participating provider, including well-care services for children.

MVP:

	What you will pay		Limitations, Exceptions & Other important Information- MVP
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Primary care visit to treat an injury or illness	$15 copay/office visit	Not covered	None
Specialist visit	$15 copay/visit	Not covered	None
Preventative care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

If you have a test

EMPIRE PLAN:

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Diagnostic test (x-ray, blood work)	$25 copayment/office visit; $50 copayment/hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	None
Imaging (CT.PET scans, MRIs)	$25 copayment/office visit; $50 copayment/hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Precertification required if not an emergency or an inpatient procedure. If not pre-certified, the cost will be greater. The test or procedure isn't covered if determined not to be medically necessary.

MVP:

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Diagnostic test (x-ray, blood work)	Lab Office - No charge; Lab Facility - No charge; Radiology Office - $15/visit; Radiology Facility - $15/visit	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
Imaging (CT.PET scans, MRIs)	Office - $15 copay/procedure; Facility - $15 copay/procedure	Not covered	None

If you need drugs to treat your illness or condition[1]

EMPIRE PLAN:

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	Certain medications require prior authorization for coverage. Copayment waived at a network pharmacy for: Oral chemotherapy drugs when used to treat cancer; tamoxifen, raloxifene (for patients age 35 & over), anastrozole & exemestane when prescribed for the primary prevention of breast cancer ; Generic oral contraceptive drugs/devices or brand name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices);Medications used for emergency contraception & pregnancy termination; Adult immunizations & certain prescription drugs & over-the-counter medications that are considered preventive under the Patient Protection & Affordable Care Act (PPACA). To learn more, go to www.hhs.gov/healthcare/about-theaca/preventive-care/index.html There is an ancillary charge for covered, non-preferred, brand-name drugs that have a generic equivalent in addition to the Level 3 copayment.
Level 1 or for most Generic Drugs	**$5 for 1-30 day supply; $10 for 31-90 day supply from a Network Pharmacy; $5 for 31-90 day supply from a Mail Service or Specialty Pharmacy**	Claims for your out-of-pocket costs may be eligible for partial reimbursement	
Level 2, preferred Drugs or compounds drugs	$30 for 1-30 day supply; $60 for 31-90 day supply from a Network Pharmacy; $55 for 31-90 day supply from a Mail Service or Specialty Pharmacy	Claims for your out-of-pocket costs may be eligible for partial reimbursement	
Level 3 or non-preferred Drugs	$60 for 1-30 day supply; $120 for 31-90 day supply from a Network Pharmacy; $110 for 31-90 day supply from a Mail Service or Specialty Pharmacy	Claims for your out-of-pocket costs may be eligible for partial reimbursement	
Specialty drugs	Applicable copayment based on the drug copayment level	Claims for your out-of-pocket costs may be eligible for partial reimbursement	

[1] See HBA for more information

MVP

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Tier 1 (Generic Drugs)	Retail $10/prescription; Mail order $25/prescription	Retail Not covered; Mail order Not covered	30 day retail/90 day mail order
Tier 2 (preferred brand drugs)	Retail $30/prescription; Mail order $75/prescription	Retail Not covered; Mail order Not covered	30 day retail/90 day mail order
Tier 3 (non-preferred Drugs)	Retail $50/prescription; Mail order $125/prescription	Retail Not covered; Mail order Not covered	30 day retail/90 day mail order
Tier 4 Specialty drugs	Retail covered as noted in Tier 1, Tier 2, and Tier 3 classes	Not covered	none

If you have outpatient surgery

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information- Empire
	Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
Facility fee (e.g ambulatory surgery center)	$25 copayment/office surgery; $50 copayment/nonhospital outpatient surgery; $95 copayment/outpatient hospital surgery	20% coinsurance in an office or ambulatory surgery center setting; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
Physician/surgeon fees	$25 copayment/surgery	20% coinsurance in an office setting	

MVP

	What you will pay		Limitations, Exceptions & Other important Information- Empire
	Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
Facility fee (e.g ambulatory surgery center)	$15copay/day	Not covered	None
Physician/surgeon fees	No Charge	Not Covered	None

If you need immediate medical attention

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Emergency Room Care	$100 copayment/visit	$100 copayment/visit	Copayment waived if admitted as inpatient directly from the Emergency Department.
Emergency medical transportation	$70 copayment/trip	$70 copayment/trip	Not subject to deductible or coinsurance.
Urgent Care	$30 copayment/visit to a freestanding urgent care center; $50 copayment/visit to a hospital-owned urgent care center	20% coinsurance in a freestanding urgent care center; 10% coinsurance or $75 (whichever is greater) for a hospital-owned urgent care center	Up to two copayments per service date may apply

MVP

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Emergency Room Care	$50 copay/visit	$50 copay/visit	None
Emergency medical transportation	No charge	No Charge	None
Urgent Care	$15 copay/visit	$15 copay/visit	None

If you have a hospital stay

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Facility fee (eg hospital room)	No Charge	10% coinsurance	Precertification required; $200 penalty if hospitalization isn't precertified.
Physician/ surgeon fees	No Charge	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.

MVP

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Facility fee (eg hospital room)	No Charge	Not covered	None
Physician/ surgeon fees	No Charge	Not covered	None

If you need mental health, behavioral health, or substance use services

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Outpatient Services	$25 copayment/visit	20% coinsurance	Precertification is required for some mental health care & substance use care
Inpatient Services	No charge	10% coinsurance	

MVP

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Outpatient Services	$15 copay/visit	Not covered	None
Inpatient Services	No charge	Not covered	None

If you are pregnant

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Office Visits	No charge for routine prenatal & postnatal care	20% coinsurance	Routine obstetrical ultrasounds may be subject to a $25 copayment when using a network provider.
Childbirth/ delivery professional services	No charge	20% coinsurance	None
Childbirth/ delivery facility services	No charge	10% coinsurance	Although precertification isn't required, it is recommended that you notify the Hospital Program if you &/or your baby are in the hospital for more than 48 hours if your baby was delivered vaginally or 96 hours if your baby was delivered by c-section

MVP

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Office Visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, &/or deductible may apply. Maternity care may include tests & services describe
Childbirth/ delivery professional services	No charge	Not covered	
Childbirth/ delivery facility services	No charge	Not covered	

If you need help recovering or have other special health needs

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information- Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Home health care	No charge	50% coinsurance	Precertification required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing.
Rehabilitation services	$25 copayment/ visit	50% coinsurance for office visits under Managed Physical Medicine Program; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.
Habilitation Services	$25 copayment/ visit	50% coinsurance	Home Care Advocacy Program (HCAP) or Managed Physical Medicine Program (MPMP) network allowance depending on the service. No charge when precertified if service is covered under HCAP. No coinsurance maximum for MPMP or HCAP services.

Skilled Nursing Care	No charge	50% coinsurance; 10% coinsurance in a skilled nursing facility	Limitations & exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission isn't precertified. No coverage for Medicare-primary enrollees. Non-network benefits apply if skilled nursing at home isn't precertified. No non-network coverage for the first 48 hours.
Durable Medical Equipment	No charge	50% coinsurance	Precertification required; non-network benefits apply if not precertified. Diabetic supplies are covered with no cost to you if you use a Home Care Advocacy Program (HCAP) provider. Non-network benefits apply if you use a non-network provide
Hospice Services	No charge	Inpatient: 10% coinsurance; Outpatient: 10% coinsurance or $75, whichever is greater	None

MVP

	What you will pay		**Limitations, Exceptions & Other important Information- Empire**
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Home health care	$15 copay/visit	Not covered	60 visits per plan year
Rehabilitation services	OP Rehab: $15 copay/visit IP Rehab: No charge	OP Rehab: Not covered IP Rehab: Not covered	OP Rehab: None IP Rehab: 30 days per Plan Year combined therapies
Habilitation Services	OP Rehab: $15 copay/visit IP Rehab: No charge	OP Rehab: Not covered IP Rehab: Not covered	OP Rehab: None IP Rehab: 30 days per Plan Year combined therapies
Skilled Nursing Care	No charge	Not covered	60 visits per plan yea
Durable Medical Equipment	20% coinsurance	Not covered	None
Hospice Services	No charge	Not covered	210 days per Plan Year; Five (5) visits for family bereavement counseling

If your child needs dental or eye care

EMPIRE PLAN

	What you will pay		Limitations, Exceptions & Other important Information-Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Children's eye exam	Not covered	Not covered	None
Children's glasses	Not covered	Not covered	None
Children's dental check-up	Not covered	Not covered	None

MVP

	What you will pay		Limitations, Exceptions & Other important Information-Empire
Services you May need	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	
Children's eye exam	$15 copay/exam	Not covered	One exam every two years
Children's glasses	Not covered	Not covered	None
Children's dental check-up	$25 copay/visit	$25 copay/visit	preventive dental services to age 1

Services Your Plan Generally Does NOT Cover [2]

EMPIRE PLAN

Cosmetic surgery *With the exception of a diagnosis of gender dysphoria & determination of medical necessity*	Long-term care
Routine foot care	Custodial care
Routine eye care (adult & child)	Weight loss programs
Dental care (adult & child), except for the correction of damage caused by an accident	Services that are experimental or investigational, or not medically necessary

MVP

Acupuncture	Private-Duty Nursing	Private-Duty Nursing
Children's Glasses	Cosmetic Surgery	Routine Foot Care
Dental Care (Adult)	Hearing Aids	Weight Loss Programs
Long-Term Care	Non-Emergency care when traveling outside the U.S	

Other covered services [3]

EMPIRE PLAN

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Diabetic Shoes
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the United States
- Telehealth

MVP

- Bariatric Care
- Chiropractic Caer
- Infertility Treatment
- Routine Eye Care

[2] (Check your policy or plan document for more information & a list of any other excluded services
[3] (limitations may apply to these services) This is not a complete list. Please see your plan document