



GENERAL INFORMATION & BOOK EMPIRE PLAN CERTIFICATE AMENDMENTS

For Employees of the State of New York
designated **Management/Confidential; Legislature**
and for their enrolled Dependents
and for COBRA enrollees with their benefits

JANUARY 2009

State of New York Department of Civil Service
Employee Benefits Division
<https://www.cs.state.ny.us>

**Keep these amendments with
your January 1, 2002 New York
State Health Insurance Program
General Information Book and
Empire Plan Certificate.**

Pages in your Book/Certificate and
later Certificate Amendments have
consecutive numbers.

Empire Plan Certificate Amendments

UnitedHealthcare/Medco Prescription Drug Program

Certificate of Insurance253

The policies and benefits described in this booklet are established by the State of New York through negotiations with State employee unions and administratively for non-represented groups. Policies and benefits may also be affected by federal and state legislation and court decisions. The Department of Civil Service, which administers the New York State Health Insurance Program (NYSHIP), makes policy decisions and interpretations of rules and laws affecting these provisions.

Where this document differs from your January 1, 2002 *NYSHIP General Information Book and Empire Plan Certificate* and later *Empire Plan Reports* and *Certificate Amendments*, this is the controlling document.

Substitute the following for the Empire BlueCross BlueShield Certificate of Insurance on pages 129-142 of your Empire Plan Certificate as amended in your January 2007 Amendments.

**Certificate
of Insurance**

**CERTIFICATE OF INSURANCE
for eligible enrollees of State of New York
(called the State)
insured by
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
Hauppauge, New York
(called UnitedHealthcare)**

UnitedHealthcare Insurance Company of New York has issued Group Policy No. 712959-G. It insures certain eligible enrollees covered by The Empire Plan. This Certificate of Insurance describes the benefits and provisions of the policy. This is a covered person's Certificate of Insurance only while that person is insured under the policy. Dependent benefits apply only to eligible dependents covered under an enrollee's family coverage if the eligible enrollee is insured under The Empire Plan for family coverage.

This Certificate describes the Plan in effect on the later of:

- A. January 1, 2009 and
- B. The date determined in accordance with the Regulations of the President of the Civil Service Commission

for Employees of the State of New York and their Dependents enrolled in The Empire Plan through Management/Confidential; Legislature (MC) and for COBRA enrollees with their benefits. It is void if issued to any other Employee. This Certificate replaces any and all Certificates previously issued to eligible enrollees under the Plan.

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Form No. 712959

**UNITEDHEALTHCARE
CERTIFICATE OF INSURANCE
Empire Plan Prescription Drug Program
Section V
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
CERTIFICATE OF INSURANCE
Empire Plan Prescription Drug Program**

UnitedHealthcare Insurance Company of New York (the “Insurer”) insures and jointly administers The Empire Plan Prescription Drug Program (the “Program”). UnitedHealthcare utilizes the administrative and mail distribution services of Medco Health Solutions, Inc. (Medco).

Meaning of Terms Used

The following terms used in this Certificate with either upper or lower case initial letters shall have the following meanings.

- A. **Appeal** means a request for review of your claim in the event a claim has been denied as not medically necessary or as a result of investigational or experimental use of a covered prescription drug in whole or in part.
- B. **Brand-Name Drug** means a prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition.
- C. **Compound Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s)** means a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA approved covered drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by this Program.
- D. **Controlled Drug** means drugs designated by Federal Law or New York State law as a Class I, II, III, IV or V substance. A Controlled Drug includes but is not limited to: some tranquilizers; stimulants; and pain medications.
- E. **Doctor** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), who is legally licensed, without limitations, to practice medicine. For benefits provided under this certificate, and for no other purpose, Doctor also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.
- F. **Exception** means a request for review of a previous decision made by The Empire Plan Prescription Drug Program that does not involve denial based

on medical necessity or as a result of an investigational or experimental use of a covered prescription drug in whole or in part.

- G. **Excluded Drug:** A drug that is excluded from coverage under this Program's benefit plan design. This Program will provide no benefit for an excluded drug and you will be responsible for paying the total retail cost of the drug. An excluded drug is not subject to any type of appeal or coverage review, including a medical necessity appeal.
- H. **Flexible Formulary:** In a flexible formulary, Brand-Name Drugs may be assigned to different copayment levels based on value to this Program and clinical judgment. In some cases, drugs may be excluded from coverage if a Therapeutic Equivalent is covered or available as an over-the-counter drug.
- I. **Generic Drug** means a drug sold under its chemical name or sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term Generic Drug shall include authorized generics marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs shall be classified as a Generic Drug.
- J. **Mail Service Pharmacy** means all facilities that are owned, operated or affiliated with Medco to fill enrollee prescriptions for all drugs covered by the Program through the mail service pharmacy process including Medco by Mail. Medco by Mail shall dispense drugs per the terms of this Certificate and in accordance with the laws, rules and regulations that govern pharmacy practice.
- K. **Medically Necessary Drug** means any drug that, as determined by the Insurer, is:
1. Provided for the diagnosis or treatment of a medical condition;
 2. Appropriate for the symptoms, diagnosis or treatment of a medical condition,
 3. Within the standards of generally accepted health care practice; and
 4. Not used for cosmetic purposes.

If your claim is denied for benefits for a drug or drugs on the basis that the drug is not medically necessary, benefits will be paid under The Empire Plan Prescription Drug Program if the drug is covered under your benefit plan design and:

- Another Empire Plan carrier has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug, and has paid benefits in accordance with Empire Plan provisions on your behalf for a medical procedure or service related to the administration of that drug; or
- Another Empire Plan carrier has liability for some portion of the expense related to the administration of that drug being provided to you, has determined the medical necessity of a medical procedure or service provided related to the administration of that drug, and has provided to you a written pre-authorization of benefits based on their determination of medical necessity, stating that The Empire Plan benefits will be available to you for a medical procedure or service related to the administration of that drug; and
- You provide to the Program proof of payment or pre-authorization of benefits from the other Empire Plan carrier based on their determination of medical necessity regarding the availability of Empire Plan benefits to

you for a medical procedure or service related to the administration of that drug.

In addition, the above provisions do not apply if another Empire Plan carrier paid benefits in error or if the expenses are specifically excluded elsewhere in this Certificate.

- L. **Network Pharmacy** means a Pharmacy, other than a Mail Service Pharmacy, that has entered into a contract with Medco as an independent contractor to dispense drugs per the terms of the contract. It must regularly dispense drugs described in the “What is Covered” section.
- M. **No-Fault Motor Vehicle Plan** means a motor vehicle plan that is required by law. It provides medical or dental care payments that are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.
- N. **Non-Network Pharmacy** means any Pharmacy, other than a Mail Service Pharmacy, that has not entered into a contract with Medco to dispense drugs. The Enrollee must file a claim form with the Insurer in order to receive reimbursement for covered drugs received from a Non-Network Pharmacy.
- O. **Non-Preferred Brand-Name Drug** means a Brand-Name Drug that has not been placed on The Empire Plan Flexible Formulary drug list by the Insurer.
- P. **Pharmacist** means a person who is legally licensed to practice the profession of pharmacy. He or she must regularly practice such profession in a pharmacy.
- Q. **Pharmacy** means an establishment that is registered as a pharmacy with the appropriate state licensing agency or is a Veterans’ Affairs medical center or hospital pharmacy, and regularly dispenses medications that require a Prescription from a Doctor. Drugs described in the section “What Is Covered” must be regularly dispensed from the Pharmacy by a Pharmacist.
- R. **Preferred Brand-Name Drug** means a Brand-Name Drug that has been placed on The Empire Plan Flexible Formulary drug list by the Insurer.
- S. **Prescription** means the written or oral request for drugs issued by a Doctor duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.
- T. **Program** means The Empire Plan Prescription Drug Program described in this Certificate.
- U. **Therapeutic Category** means categories by which drugs are identified and grouped by the main conditions they treat.
- V. **Therapeutic Equivalent** means prescription drug products that, when compared, can be expected to produce essentially the same therapeutic outcome and toxicity as determined by the Insurer.
- W. **Workers’ Compensation Law** means a law that requires employees to be covered, at the expense of the employer, for benefits in case they are disabled because of accident or sickness or billed due to a cause connected with their employment.
- X. **You, your, or yours** refers to you, the eligible enrollee to whom this Certificate is issued. It also refers to your eligible enrolled dependents who are covered under this Program. For information on eligibility, refer to your *New York State Health Insurance Program General Information Book*.

The information below explains your benefits and responsibilities in detail.

Your Benefits and Responsibilities

Copayments

Copayments for covered drugs are based on the drug, the days' supply and whether the Prescription is filled at a Network Pharmacy or a Mail Service Pharmacy.

When you fill your Prescription for a covered drug for up to a **30-day supply at a Network Pharmacy or through a Mail Service Pharmacy**, your copayment is:

- **\$5** for a **Generic** Drug or a Level 1 Drug
- **\$15** for a **Preferred Brand-Name** Drug, Compound Drug or a Level 2 Drug
- **\$40** for a **Non-Preferred Brand-Name** Drug, or a Level 3 Drug

When you fill your Prescription for a **31- to 90-day supply at a Network Pharmacy**, your copayment is:

- **\$10** for a **Generic** Drug or a Level 1 Drug
- **\$30** for a **Preferred Brand-Name** Drug, Compound Drug or a Level 2 Drug
- **\$70** for a **Non-Preferred Brand-Name** Drug or a Level 3 Drug

When you fill your Prescription for a **31- to 90-day supply through a Mail Service Pharmacy**, your copayment is:

- **\$5** for a **Generic** Drug or a Level 1 Drug
- **\$20** for a **Preferred Brand-Name** Drug, Compound Drug or a Level 2 Drug
- **\$65** for a **Non-Preferred Brand-Name** Drug or a Level 3 Drug

One copayment covers up to a 90-day supply. Refills are valid for up to one year from the date the Prescription is written.

If the full cost of the drug is less than your copayment, your cost is the lesser amount.

Supply and Coverage Limits

Certain drugs may be subject to quantity level limits based on clinical and safety factors related to the dispensing of the medication. Additional quantity level limits are based on criteria developed by the Insurer. Days supply for Controlled Drugs are in accordance with Federal and State mandates.

Erectile dysfunction drugs are limited to a specific quantity per day supply; 6 units for a 30-day supply and 7-18 units for a 31- to 90-day supply.

Mandatory Generic Substitution

When your Prescription is written Dispense As Written (DAW) for a Brand-Name Drug that has a generic equivalent, you pay the Non-Preferred Brand-Name copayment plus the difference in cost between the Brand-Name and the Generic Drug, not to exceed the full retail cost of the drug. When your Prescription is not written DAW, in most cases, the generic equivalent is substituted for the Brand-Name Drug and you pay the Generic Drug copayment.

The following Brand-Name Drugs are excluded from mandatory generic substitution: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid and Tegretol. For these drugs, you pay only the applicable copayment, which in most cases will be the Non-Preferred Brand-Name copayment.

If your Doctor believes it is Medically Necessary for you or your family member to have a Brand-Name Drug (that has a generic equivalent), you may appeal the mandatory generic substitution requirement. To begin the appeal process, your Doctor should call toll free 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

Act promptly. If your appeal is approved, upon request, the Insurer will adjust claims processed by a pharmacy within 30 days from the date the Insurer received all information needed to decide the appeal.

If your appeal is granted and you fill your prescription for a Brand-Name Drug at a Network Pharmacy or through a Mail Service Pharmacy, you pay the Non-Preferred copayment. If your appeal is denied, you can make a second appeal to the Insurer.

Empire Plan Flexible Formulary

Under The Empire Plan Flexible Formulary plan design drugs are classified by therapeutic category or medical condition in order to manage prescription costs without affecting the quality of care. A therapeutic category is a group of drugs that treat a specific health condition or that work in a certain way. For example, antibiotics are used for the treatment of infections.

Drugs on The Empire Plan Flexible Formulary are grouped into Levels and your copayment is determined by the “Level” that your medication is on.

- A. Level 1 drugs have the lowest copayment and include all Generic Drugs.
- B. Level 2 drugs have the mid-range copayment and include Preferred Brand-Name Drugs that have been selected because of their overall healthcare value.
- C. Level 3 drugs have the highest copayment and include Non-Preferred Brand-Name Drugs.

The Flexible Formulary works with The Empire Plan Prescription Drug Program plan design as described below:

- A. When clinically appropriate and financially advantageous to this Program, Brand-Name Drugs may be available on Level 1;
- B. Certain therapeutic categories of prescription drugs with two or more clinically sound and therapeutically equivalent Level 1 options may not have a Brand-Name Drug in Level 2; and
- C. Access to one or more drugs in select therapeutic categories may be excluded (not covered) if the drug(s) has no clinical advantage over other Generic Drug(s) and Brand-Name Drug(s) in the same therapeutic category. Drugs considered to have no clinical advantage that may be excluded include any products that:
 - 1. Contain one or more active ingredients available in and therapeutically equivalent to another covered prescription drug in the therapeutic category or in an over-the-counter drug; or
 - 2. Contain one or more active ingredients which is a modified version of and therapeutically equivalent to another covered prescription drug or in an over-the-counter drug.

Please refer to the Exclusions and Limitations section of the Certificate for a list of drugs not covered by The Empire Plan Prescription Drug Program.

Periodically, the Program may offer enrollees taking certain prescription medications covered under the benefit design an instant rebate of the copayment for that particular prescription drug.

Prior authorization required for certain drugs

You must have prior authorization to receive Empire Plan Prescription Drug Program benefits for certain medications. If your Doctor prescribes one of these drugs, the Insurer will request from your Doctor the clinical information required to authorize coverage of the medication. Your Pharmacy or Doctor may contact the Insurer to begin the authorization process. The Insurer and/or pharmacy will notify you of the results of the review. The prior authorization requirements apply whether you use your Empire Plan Benefit

Card or will be filing a claim for direct reimbursement. The following is a list of drugs (including generic equivalents) that require prior authorization:

- | | | | |
|------------------|--------------------|--------------|---------------------|
| • Amevive | • Growth Hormones | • Lamisil | • Roferon-A |
| • Aranesp | • Humira | • Letairis | • Synagis |
| • Avonex | • Immune Globulins | • Myobloc | • Tracleer |
| • Betaseron | • Increlex | • Orencia | • Tysabri |
| • Botox | • Infergen | • Pegasys | • Ventavis |
| • Cimzia | • Intron-A | • Peg-Intron | • Weight Loss Drugs |
| • Copaxone | • Iplex | • Provigil | • Xolair |
| • Enbrel | • Kineret | • Rebif | |
| • Epogen/Procrit | • Kuvan | • Remicade | |
| • Flolan | | • Remodulin | |
| • Forteo | | • Revatio | |

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds \$100 will require Prior Authorization under this Program. This list of drugs is subject to change. For the most current list of drugs requiring prior authorization, call The Empire Plan Prescription Drug Program at the number below or go to the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. For more information about drugs requiring prior authorization and how to obtain it, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program.

If the prior authorization review results in authorization for payment, you will receive Empire Plan Prescription Drug Program benefits for the drug. If the payment is not authorized, no Empire Plan Prescription Drug Program benefits will be paid for the drug.

An appeal process allows you or your Doctor to ask for further review if authorization is not granted. You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program for information on how to initiate an appeal.

What is Covered

You are covered for the following prescription drugs or medicines when they are covered under this Program's benefit design, Medically Necessary and dispensed by a Pharmacy:

- A. FDA approved drugs that must bear the legend: RX Only.
- B. State Restricted Drugs. Drugs or medicines that can be dispensed in accordance with New York State Law (or by the laws of the state or jurisdiction in which the Prescription is filled) by Prescription only
- C. Compound Drug(s)/Medication(s)
- D. Injectable insulin
- E. Oral, injectable or surgically implanted contraceptives that bear the legend RX Only, diaphragms and contraceptive devices
- F. Vitamins, which are FDA approved prescription drugs and bear the legend RX Only.
- G. Covered prescription drugs dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility; rest home; sanitarium; extended care facility; convalescent hospital; or similar facility. Such on-premises pharmacies are considered Non-Network Pharmacies and require submission of a claim form for reimbursement.
- H. Claims for drugs dispensed outside of the U.S. that have an available U.S. FDA approved equivalent.

Please refer to the section “*Exclusions and Limitations*” below for conditions under which benefits for the above are not available.

Exclusions and Limitations

Charges for the following items are **not** covered expenses:

- A. Drugs obtained with no prescription order, including over the counter products except insulin
- B. Drugs taken or given at the time and place of the prescription order and billed by the Doctor
- C. Drugs provided or required by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay
- D. Drugs for which there is no charge or legal obligation to pay in the absence of insurance
- E. Drugs administered to you by the facility while a patient in a licensed hospital

This limit applies only if the hospital in which you are a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals; and dispenses such drugs administered to you by the hospital.

- F. Any drug refill that is more than the number approved by the Doctor
- G. Contraceptive jellies, ointments and foams or devices not requiring a Doctor’s order, prescribed for any reason
- H. Contraceptive Intrauterine Devices (I.U.D.) that do not contain any FDA approved hormone prescription drug products.
- I. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments or other non-medicinal substances), regardless of their intended use
- J. The administration of any drug or injectable insulin
- K. Any drug refill that is dispensed more than one year after the original date of the prescription order
- L. Any drug labeled “Caution: Limited by Federal Law to Investigational Use,” or experimental drugs except for drugs used for the treatment of cancer as specified in Section 3221(1)12 of New York State Insurance Law as may be amended from time to time: Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or any drug that the U.S. Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Experimental or investigational drugs shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. For external appeal provisions, see “*Your right to an External Appeal*” under Miscellaneous Provisions. If the External Appeal Agent approves coverage of an experimental or investigational drug that is part of a clinical trial, only the costs of the drug will be covered. Coverage will not be provided for the costs of experimental or investigational drugs or devices, the costs of non-health care services, the costs of managing research or costs not otherwise covered by The Empire Plan for non-experimental or non-investigational drugs provided in connection with such clinical trial.

- M. Immunizing agents, biological sera, blood or blood plasma, except immune globulin
- N. Any drug that a Doctor or other health professional is not authorized by his or her license to prescribe

- O. Drugs for an injury or sickness related to employment for which benefits are provided by any State or Federal workers' compensation, employers' liability or occupational disease law or under Medicare or other governmental program, except Medicaid
- P. Drugs purchased prior to the start of coverage or after coverage ends
However if the person is totally disabled on the date this insurance ends, see *"Benefits after termination of coverage"*.
- Q. Any drug prescribed and/or dispensed in violation of State or Federal law
- R. Prescription drug products excluded from the benefit plan design, including: Adoxa, Caduet, Coreg CR, Doryx, Kapidex, Nexium (capsules or suspension), Prevacid (capsules), Testim, Treximet, Veramyst, Omnitrope, Genotropin (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Humatrope (except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age), and Norditropin (except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age).
- S. New Prescription Drug Products that are in the same therapeutic category as existing drugs excluded under The Empire Plan Flexible Formulary or that are in the same therapeutic category as drugs excluded from benefit coverage under this Plan.
- T. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include but are not limited to:
 - 1. Non-amphetamine anorexiant, except for morbid obesity
 - 2. Amphetamines that are prescribed for weight loss, except for morbid obesity
 - 3. Products used to promote hair growth
 - 4. Products (ex. Retinoic Acid) used for prevention of skin wrinkling
- U. Coverage for drugs where the amount dispensed exceeds the supply limit.
- V. Coverage for drugs as a replacement for a previously dispensed drug.
- W. Products for which the primary use is nutrition.
- X. Any non-medically necessary drugs
- Y. Claims for foreign drugs for which there is no available US equivalent approved by the FDA

IMPORTANT: See your *NYSHIP General Information Book and Empire Plan Certificate* for other conditions that may affect this coverage. See especially the Home Care Advocacy Program (HCAP) section of your UnitedHealthcare Certificate for coverage for prescription drugs billed by a home care agency.

How to Use Your Empire Plan Prescription Drug Program

When your Doctor prescribes a Medically Necessary Drug covered under The Empire Plan, you can fill the prescription for a supply of up to 90 days and refills for up to one year in one of three ways: at a Network Pharmacy, at a Non-Network Pharmacy or through a Mail Service Pharmacy.

When your Doctor starts you on a new medication, you may want to have your prescription filled for a 30-day supply to ensure the prescription medication is right for your condition.

Network Pharmacies

You can use your Empire Plan Benefit Card for covered prescription drugs at Empire Plan Network Pharmacies. Be sure your Pharmacist knows that you and your family have Empire Plan Prescription Drug Program coverage.

To find a Network Pharmacy, check with your Pharmacist or call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program or go to the web site at <https://www.cs.state.ny.us>. Many retail pharmacies in New York State participate in this Program. Many out-of-State pharmacies participate, as well. All Empire Plan Network Pharmacies can fill Prescriptions for supplies of up to 90 days. Refills of covered drugs are provided for up to a year from the date the Prescription is written. Only one copayment applies for up to a 90-day supply.



Non-Network Pharmacies

You can use a Non-Network Pharmacy or pay the full amount for your Prescription at a Network Pharmacy (instead of using your Empire Plan Benefit Card) and fill out a claim for reimbursement.

In almost all cases, you will not be reimbursed the total amount you paid for the Prescription and your out-of-pocket expense may exceed the usual

copayment amount. To reduce your out-of-pocket expenses, use your Empire Plan Benefit Card whenever possible.

Out-of-pocket expenses: When you use a Non-Network Pharmacy or pay the full amount for your Prescription at a Network Pharmacy, you are responsible for the difference between the amount charged and the amount you are reimbursed under this Program.

For claim forms, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program or download one from the web site at <https://www.cs.state.ny.us>.

Mail the completed form with your bills or receipts to:

Medco Health Solutions
P.O. Box 14711
Lexington, KY 40512

Several factors affect the amount of your reimbursement. If your Prescription was filled with:

- A Generic Drug, a Brand-Name Drug with no generic equivalent or insulin, you will be reimbursed up to the amount this Program would reimburse a Network Pharmacy for that Prescription as calculated using the Program's standard reimbursement rate for Network Pharmacies less the applicable copayment.
- A Brand-Name Drug with a generic equivalent (other than drugs excluded from mandatory generic substitution), you will be reimbursed up to the amount this Program would reimburse a Network Pharmacy for filling the Prescription with that drug's generic equivalent as calculated using the Program's standard reimbursement rates for Network Pharmacies less the applicable copayment, which in most cases will be the Non-Preferred copayment.

Deadline for filing claims

Claims must be submitted within 90 days after the end of the calendar year in which the prescription drugs were purchased, or 90 days after another plan processes your claim, whichever is later, unless it was not reasonably possible for you to meet this deadline (for example, due to your illness).

Mail Service Pharmacy

All drugs covered by the Program can be ordered through a Mail Service Pharmacy. You can order and receive up to a 90-day supply of your Prescriptions, shipped by first class mail or private carrier. You can pay your copayment(s) and other

costs by credit card, check or money order. To request mail service envelopes, refills or to speak to a Pharmacist about your mail service Prescription, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program, 24 hours a day, seven days a week.

The Mail Service Pharmacy address is:

Medco by Mail
P.O. Box 6500
Cincinnati, OH 45201-6500

Using The Empire Plan Flexible Formulary drug list

One way you can help control the rapidly increasing cost of prescription drugs is to encourage your Doctor(s) to prescribe and Pharmacist to dispense Generic and Preferred Drugs listed on The Empire Plan Flexible Formulary drug list. (The Empire Plan Flexible Formulary drug list is available at <https://www.cs.state.ny.us>.)

This list provides the most commonly prescribed Generic and Brand-Name Drugs included on The Empire Plan Flexible Formulary drug list. These medications are safe and effective alternatives to higher cost drugs. Using Prescription drugs that appear on this list will save you money. Using Generics will save you even more.

The Insurer will provide the Flexible Formulary drug list to you and to Empire Plan participating Doctors. Doctors are encouraged - but not required - to use this list.

Remember, if your Doctor prescribes a prescription drug that is excluded from coverage under The Empire Plan benefit plan design, you will pay the full retail cost for your prescription.

Help control the rising cost of the prescription drug program by asking your Doctor to prescribe a drug that is appropriate for you from the Flexible Formulary drug list.

Half Tablet/Pill Splitting Program

The Half Tablet Program provides an opportunity for you to reduce your prescription medication copayments for certain eligible medications by using double strength tablets and splitting them in half.

This program is voluntary.

To participate in the Half Tablet Program, ask your Doctor to write a new Prescription for an eligible medication for twice the dosage and half the quantity, with directions to take half the tablet at the regularly scheduled time. When the Prescription is filled at either a Network pharmacy or through a Mail Service Pharmacy, the copayment is automatically cut in half. For an updated list of the medications eligible for the Half Tablet Program, go to <https://www.cs.state.ny.us> and select Benefits Programs in the left-hand navigation on the home page. Follow the prompts to NYSHIP Online, then choose Find a Provider. Scroll to the Medco links and click Empire Plan Half Tablet Program.

Contact The Empire Plan Prescription Drug Program

For questions about your Empire Plan Prescription Drug Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan Prescription Drug Program. The Teletypewriter (TTY) number for callers with a hearing or speech disability is 1-800-759-1089.

Call 24 hours a day, 7 days a week if you need to:

- Verify your eligibility
- Find out if your claims have been paid

- Locate an Empire Plan Network Pharmacy
- Order refills from a Mail Service Pharmacy or check order status
- Talk to a customer service representative
- Request prior authorization or a generic appeal
- Talk to a Pharmacist

Go to <https://www.cs.state.ny.us>, select Benefit Programs and follow the prompts to NYSHIP Online. Then choose Find a Provider and scroll to the Medco links if you need to:

- Locate an Empire Plan Network Pharmacy
- Order refills online from Medco by Mail or check order status
- Download a Medco by Mail order form
- View the list of drugs subject to prior authorization or eligible for the Half Tablet Program
- View the 2009 Flexible Formulary drug list.

Coordination of Benefits

A. **Coordination of Benefits** means that the benefits provided for you under The Empire Plan Prescription Drug Program are coordinated with the benefits provided for you under another group plan. The purpose of Coordination of Benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the total allowable charge for a service covered under both group plans. If a covered drug is submitted under the Program, the Program will reimburse the enrollee the submitted balance or the amount that would have been paid as a network benefit under The Empire Plan, whichever is lower. In addition, if you or any of your dependent(s) is covered under two separate Empire Plan policies, you may submit Empire Plan copayments for reimbursement under your secondary Empire Plan coverage using a paper claim form.

B. Definitions

1. **Plan** means a plan that provides benefits or services for or by reason of medical or dental care and that is:
 - a. A group insurance plan; or
 - b. A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
 - c. A self-insured or non-insured plan; or
 - d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
 - e. A group service plan; or
 - f. A group prepayment plan; or
 - g. Any other plan that covers people as a group; or
 - h. A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
2. **Order of Benefit Determination** means the procedure used to decide which plan will determine its benefits before any other plan. Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan that reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts that do not.

- C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the total allowable charge for the service you receive.
- D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has a Coordination of Benefits or similar provision with the same order of benefit determination as stated in Item E. and under that order of benefit determination, the benefits under The Empire Plan are to be determined before the benefits under the other plan.
- E. When more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules that applies:
 - 1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent;
 - 2. When this Plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are **not** divorced or separated (For coverage of a dependent of parents who are divorced or separated, see paragraph 3. below)
 - a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year but;
 - b. If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time;
 - c. If the other plan does not have the rule described in subparagraphs a. and b. above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits; and
 - d. The word birthday refers only to month and day in a calendar year, not the year in which the person was born.
 - 3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent with custody of the child;
 - c. Finally, the plan of the parent not having custody of the child; and
 - d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.
 - 4. The benefits of a plan that covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan that covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule and if as a result the plans do not agree on the order of benefits, this Rule 4. is ignored.
 - 5. If none of the rules in 1. through 4. above determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.

- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
- G. Any information about covered expenses and benefits that is needed to apply this provision may be given or received without the consent of or notice to any person, except as required by Article 25 of the General Business Law.
- H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, there is a right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other plan.
- I. If payments that should have been made under The Empire Plan have been made under other plans, the party that made the other payments will have the right to receive any amounts that are considered proper under this provision.

Medicare Prescription Drug Coverage

If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, read the following information about how to use your Empire Plan benefits for secondary coverage.

A Medicare-primary Empire Plan enrollee or dependent enrolled in a Medicare Part D drug plan must use his or her Medicare Part D prescription drug program first. Any amounts not covered by your Medicare Part D plan, such as deductibles, copayments and charges for non-covered drugs, can be submitted to The Empire Plan for consideration using The Empire Plan Prescription Drug Program claim form specifically labeled Medicare Part D Secondary Claim Form. This claim form is available on the New York State Department of Civil Service web site, <https://www.cs.state.ny.us>. The form is also available by calling The Empire Plan Prescription Drug Program at 1-877-7-NYSHIP (1-877-769-7447). When you call, be sure to ask for the Medicare Part D claim form.

At Network Pharmacies: Any claim submitted to The Empire Plan Prescription Drug Program by a Network Pharmacy will be rejected and the Pharmacist will be advised that you have alternate insurance, which is your Medicare Part D drug plan. You are responsible for providing the Pharmacist with the necessary Medicare Part D plan information to submit the claim. Then, you must follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

At Mail Service Pharmacies: Any prescription sent to a Mail Service Pharmacy for a Medicare-primary Empire Plan enrollee or dependent who is also enrolled in a Medicare Part D drug plan will be rejected and returned. You must use your Medicare Part D drug plan first and then follow the instructions described above to submit a paper claim to The Empire Plan Prescription Drug Program for any additional reimbursement to which you may be entitled.

IMPORTANT: If you or a covered dependent is eligible for Medicare-primary coverage and have enrolled in a Medicare Part D prescription drug plan, you must submit your out-of-pocket expenses to The Empire Plan Prescription Drug Program using The Empire Plan Prescription Drug Program Medicare Part D Secondary Claim Form only. Your claim will be processed in accordance with the coordination of benefits provisions of The Empire Plan Prescription Drug Program. If you use the standard Empire Plan Prescription Drug Program claim form, your claim will be rejected and you will have to resubmit it using the Medicare Part D Secondary Claim Form.

Miscellaneous Provisions

Termination of coverage

- A. Coverage will end when you are no longer eligible to participate in this Program. Refer to the eligibility section of your *NYSHIP General Information Book*.
Under certain conditions, you may be eligible to continue coverage under The Empire Plan temporarily after eligibility ends. Refer to the COBRA section of your *NYSHIP General Information Book*.
- B. If this Program ends, your Program coverage will end.
- C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your *NYSHIP General Information Book*.
Under certain conditions, dependent(s) of employees or former employees may be eligible to continue coverage under The Empire Plan temporarily after eligibility ends. Refer to the COBRA section of your *NYSHIP General Information Book*.
- D. If a payment that is required from you toward the cost of The Empire Plan coverage is not made, the coverage will end on the last day of the period for which a payment was made.
- E. If coverage ends, any claim incurred before your coverage ends for any reason will not be affected; also, see “*Benefits after termination of coverage*” below.

Benefits after termination of coverage

You may be Totally Disabled on the date coverage ends on your account. If so, benefits will be provided on the same basis as if coverage had continued with no change until the day you are no longer Totally Disabled or for three months after the date your coverage ended, whichever is earlier.

Totally Disabled means that because of a sickness or injury you, the enrollee, cannot do your job, or any other work for which you might be trained, or your dependent cannot do his or her usual duties.

Request for repayment of benefits

The Insurer will seek reimbursement from you for any money paid on behalf of you or your dependents for expenses incurred after loss of eligibility for benefits for any reason. Use of The Empire Plan Benefit Card after eligibility ends constitutes fraud.

Audits/prescription benefit records

From time to time, the Insurer may ask you to verify receipt of particular drugs from Network Pharmacies or from a Mail Service Pharmacy. These requests are part of the auditing process. Your cooperation may be helpful in identifying fraudulent practices or unnecessary charges to your plan. All such personal information will remain confidential.

Legal action

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive written notice that benefits have been denied.

Appeals

Coverage Exceptions: Flexible Formulary

Coverage for prescription drugs excluded and/or limited in quantity under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under The Empire Plan Flexible Formulary.

Non-Preferred Brand-Name Drugs covered under the Program are subject to the Level 3 copayment. Under the Program benefit design, copayment exceptions are not permitted.

Claims appeal: 60-day deadline

In the event a claim has been denied as not medically necessary or as a result of investigational or experimental use of a covered prescription drug, you can request a review of your claim. This request for review should be sent to the Claims Review Unit at the following address within 60 days after you receive notice of denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data questions or comments you deem appropriate.

To request a review of your claim, write to:

The Empire Plan Prescription Drug Program
UnitedHealthcare
P.O. Box 5900
Kingston, NY 12402-5900

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, One Commerce Plaza, Albany, NY 12257. Phone: 1-800-342-3736, Monday - Friday, 9 a.m. – 5 p.m.

Your right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Insurer has denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

Your right to appeal a determination that a drug is not medically necessary

If you have been denied coverage on the basis that the prescription drug is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

- A. The prescription drug must otherwise be covered under The Empire Plan Prescription Drug Program; and
- B. You must have received a final adverse determination through the internal appeal process described above and the Insurer must have upheld the denial or you and the Insurer must agree in writing to waive any internal appeal.

Your rights to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the drug is experimental or investigational, you must satisfy the following two criteria:

- A. The prescription drug must otherwise be covered under The Empire Plan Prescription Drug Program; and
- B. You must have received a final adverse determination through the internal appeal process described above and the Insurer must have upheld the denial or you and the Insurer must agree in writing to waive any internal appeal.

In addition, your attending Doctor must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one that, according to the current diagnosis of your attending Doctor, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the

age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending Doctor must also certify that your life-threatening or disabling condition or disease is one for which standard drugs are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard drug or procedure covered by the Program.

In addition, your attending Doctor must have recommended a drug that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered drug. (Only certain documents will be considered in support of this recommendation. Your attending Doctor should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable.)

For the purposes of this section, your attending Doctor must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal process

If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the prescription drug is not medically necessary or is an experimental or investigational drug, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Insurer have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Insurer will provide an external appeal application with the final adverse determination issued through the Insurer’s internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the Insurer based its denial, the External Appeal Agent will share this information with the Insurer in order for it to exercise its right to reconsider its decision. If the Insurer chooses to exercise this right, the Insurer will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Insurer does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Doctor or the Insurer. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending Doctor certifies that a delay in providing the prescription drug that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and the Insurer by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision. If the External Appeal Agent overturns the Insurer’s decision that

a service is not medically necessary or approves coverage of an experimental or investigational drug, the Insurer will provide coverage subject to the other terms and conditions of the Program.

The External Appeal Agent's decision is binding on both you and the Insurer. The External Appeal Agent's decision is admissible in any court proceeding.

The Insurer will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. The Insurer will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an External Appeal

It is **YOUR RESPONSIBILITY** to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your Doctor may file an external appeal application on your behalf, but only if you have consented to this in writing.

45-day deadline

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Insurer that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Insurer has no authority to grant an extension of this deadline.

More About Your Empire Plan Prescription Drug Program Drug Utilization Review (DUR)

Prescription drugs can work wonders in curing ailments and keeping you healthy — often at a cost much lower than surgery or other procedures. But they can also cause serious harm when taken in the wrong dosage or in a harmful combination with another drug.

DUR identifies possible problems

Your Empire Plan Prescription Drug Program includes a Drug Utilization Review (DUR) program to check for possible inappropriate drug consumption, medical conflicts or dangerous medication interactions.

The DUR process

This review process generally asks:

- Is the Prescription written for the recommended daily dose?
- Is the patient already taking another drug that might conflict with the newly prescribed drug?
- Does the patient's prescription drug record indicate a medical condition that might be made worse by this drug?
- Has the age of the patient been taken into account in prescribing this medication?
- Is the patient taking a quantity of medication that is consistent with the Doctor's directions on the prescription?

When you use your card

When you use your Empire Plan Benefit Card at a Network Pharmacy or a Mail Service Pharmacy and the Pharmacist enters the information into the computer, the computer system will review your recent Empire Plan Prescription Drug Program medication history. If a possible problem is found, a warning message will be flashed to your Pharmacist.

The Pharmacist may talk with you and your Doctor. Once any issues are resolved, the appropriate medication can be dispensed.

Safety

In addition, a “behind the scenes” safety review is conducted to identify any potential drug therapy related problems. If a potential problem is detected, the information is reviewed by a clinical Pharmacist who notifies your Doctor of the possible risks. If two prescribing Doctors are involved, both will be notified of the potential problem.

If, as the result of DUR, it is determined that a member may be using prescription medications in a harmful or abusive manner or with harmful frequency, the Plan reserves the right to limit an enrollee to the use of a single network pharmacy plus the Mail Service Pharmacy.

This process helps your Doctor make more informed decisions about your prescription drugs.

Refill Too Soon

A key component of the DUR safety process implemented for this Program is the application of the “refill too soon” (RTS) edit for all claims submitted under the Program. The RTS program ensures that The Empire Plan Prescription Drug Program provides safety and utilization review across all supply chains; Network Pharmacy claims, Mail Service Pharmacy claims and Non-Network Pharmacy claims processed for an individual enrollee. Upon processing of an incoming claim, the previous 180 days of an enrollee’s prescription drug claim history are reviewed by the systematic RTS criteria. The RTS edit will cause the claim to reject if the enrollee has consumed (based on days supply) less than 75 percent of their medication on a cumulative basis over the past 180 days. When a claim is rejected, the Pharmacist is sent a message indicating the next refill date for the enrollee. The RTS will also take into account the cumulative days supply on hand.

Confidential Service

Confidentiality is key. You can be assured that these reviews are confidential and that pertinent information is shared only with your Pharmacist and Doctor or as permitted or required by law.

Education is the Right Prescription

For patients

It’s important that you understand the drugs being prescribed for you – what they will do and how they should be taken. To help you with that understanding, The Empire Plan Prescription Drug Program has a patient education program.

For doctors

To help your Doctor keep up to date on the most current information on prescription drugs, The Empire Plan has a doctor education program.

Notes

Notes



State of New York
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
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New York State Health Insurance Program

**Important. Prescription Drug Certificate Amendment
For the Enrollee, Enrolled Spouse/Domestic Partner
and Other Enrolled Dependents**

MC Book/Certificate Amendment - January 2009

CHANGE SERVICE REQUESTED

**Please do not send mail or
correspondence to the return
address. See below for
address information.**

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 (<https://www.cs.state.ny.us>). Click on Employee Benefits 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 may call 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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This *Empire Plan Certificate Amendment* 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 through The Empire Plan.



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**SAVE THIS AMENDMENT
IMPORTANT INFORMATION ABOUT
THE NEW YORK STATE HEALTH
INSURANCE PROGRAM**

This Amendment is for employees designated Management/Confidential; Legislature and enrolled in The Empire Plan.

Benefit changes that are mailed to you are also posted on our web site, <https://www.cs.state.ny.us>. Click on Benefit Programs, then NYSHIP Online. Choose your group, if prompted, and click on Using Your Benefits. Select the Publications link.