At A GLANCE

JANUARY 2025

MC; Legislature • Management/ Confidential; Legislature

For Employees of the State of New York designated Management/ Confidential; Legislature and for their enrolled Dependents; and for COBRA Enrollees and Young Adult Option Enrollees with their Empire Plan benefits

This guide briefly describes Empire Plan benefits. It is not a complete description and is subject to change. For a complete description of your benefits and responsibilities, refer to your *Empire Plan Certificate* and *Certificate Amendments*.

For information regarding your New York State Health Insurance Program (NYSHIP) eligibility or enrollment, contact your Health Benefits Administrator. If you have questions regarding specific benefits or claims, contact the appropriate Empire Plan administrator (see page 19).

NEW YORK STATE | Department of Civil Service
The Empire Plan

New York State Department of Civil Service Employee Benefits Division
Albany, NY 12239 | www.cs.ny.gov/employee-benefits

WHAT'S NEW

- **In-Network Out-of-Pocket Limit** – As of January 1, 2025, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan is $4,120 for Individual coverage and $8,240 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Use and Prescription Drug Programs. The limits are determined by the amount of the negotiated salary increase from the prior year. See page 3 for more information.
- **2025 Empire Plan Advanced Flexible Formulary Drug List** – The 2025 Advanced Flexible Formulary lists the most commonly prescribed generic and brand-name drugs along with any excluded drugs with formulary alternatives. You can access the Advanced Flexible Formulary on the NYSHIP website at www.cs.ny.gov/employee-benefits.
- **Insulin Coverage** – Effective January 1, 2025, covered prescription insulin drugs will not be subject to a deductible, copayment, coinsurance or any other cost-sharing requirement.
- **Annual Mammogram Screening Coverage** – The Empire Plan covers annual mammogram screenings at no cost when an enrollee uses a network facility or provider. New York State mandates annual mammogram screening coverage even though the federal recommendation is only once every two years for most patients.
- **Dental Plan Administrator Changed to Anthem Blue Cross** – Effective October 1, 2024, the New York State Dental Plan administrator changed from EmblemHealth to Anthem Blue Cross. There is no impact or change to dental benefits as a result of this transition. Enrollees and covered dependents have access to an expanded network of dental providers offering the highest quality of care.

Quick Reference

The Empire Plan is a comprehensive health insurance program for New York's public employees and their families. The Plan has four main parts:

Hospital Program

administered by Anthem Blue Cross

Provides coverage for inpatient and outpatient services provided by a hospital or skilled nursing facility and hospice care. Includes the Center of Excellence for Transplants Program. Also provides inpatient Benefits Management Program services, including preadmission certification of hospital admissions and admission or transfer to a skilled nursing facility, concurrent reviews, discharge planning, inpatient medical case management, Site of Care Program for Infusions and the Building Healthy Families Program.

Medical/Surgical Program

administered by UnitedHealthcare

Provides coverage for medical services, such as office visits, surgery, diagnostic testing and urgent care visits under the Participating Provider, Basic Medical and Basic Medical Provider Discount Programs. Coverage for physical therapy, chiropractic care and occupational therapy is provided through the Managed Physical Medicine Program.

Also provides coverage for home care services, durable medical equipment and related medical supplies through the Home Care Advocacy Program; the Prosthetics/Orthotics Network; Center of Excellence Programs for Cancer and for Infertility; and Benefits Management Program services, including Prospective Procedure Review for MRIs, MRAs, CT scans, PET scans, nuclear medicine tests, voluntary specialist consultant evaluation services, outpatient medical case management and the Empire Plan NurseLine℠ for health information and support.

Mental Health & Substance Use Program

administered by Carelon Behavioral Health

Provides coverage for inpatient and outpatient mental health and substance use care services. Also provides precertification of inpatient and certain outpatient services, concurrent reviews, case management and discharge planning.

Prescription Drug Program

administered by CVS Caremark

Provides coverage for prescription drugs dispensed through Empire Plan network pharmacies, the CVS Mail Service Pharmacy, the CVS Specialty Pharmacy and non-network pharmacies.

See *Contact Information* on page 19.

Benefits Management Program

The Empire Plan Benefits Management Program helps to protect the enrollee and allows the Plan to continue to cover essential treatment for patients by coordinating care and avoiding unnecessary services. The Benefits Management Program precertifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient medical case management. In order to receive maximum benefits under the Plan, you must follow the Benefits Management Program requirements. This includes obtaining precertification for certain services when The Empire Plan is your primary coverage (pays first, before another health plan or Medicare).

If The Empire Plan is primary for you or your covered dependents, you must call The Empire Plan and choose the Hospital Program (see *Contact Information*, page 19) for preadmission certification:

- Before a scheduled (nonemergency) hospital admission, skilled nursing facility admission/transfer or transplant surgery.*
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.*
- For admission resulting from complications due to pregnancy or for any reason other than the delivery of the baby.* It is also recommended that you call if you or your baby are hospitalized for more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery.

If you do not call and the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.

** These services are subject to a $200 penalty if the hospitalization is determined to be medically necessary, but not precertified.*

Other Benefits Management Program services provided by the Hospital Program include:

- Concurrent review of hospital inpatient treatment
- Discharge planning for medically necessary services post-hospitalization
- Inpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care
- The Building Healthy Families Program for access to pre-pregnancy, maternity and postpartum care and parenting support

If The Empire Plan is primary for you or your covered dependents, you must call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 19) for Prospective Procedure Review before receiving the following scheduled (nonemergency) diagnostic tests:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computerized tomography (CT) scan
- Positron emission tomography (PET) scan
- Nuclear medicine test

Precertification is required unless you are having the test as an inpatient in a hospital. If you do not call, you will pay a larger part of the cost. If the test or procedure is determined not to be medically necessary, you will be responsible for the entire cost.

Other Benefits Management Program services provided by the Medical/Surgical Program include:

- Coordination of voluntary specialist consultant evaluation
- Outpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care

Be sure to review the Benefits Management Program section of your *Empire Plan Certificate* and subsequent *Certificate Amendments* for complete information on the program's services and requirements.

Out-of-Pocket Costs

In-Network Out-of-Pocket Limit

The federal Patient Protection and Affordable Care Act (PPACA) sets new annual amounts that limit total network out-of-pocket costs and they apply unless the Plan sets lower limits. As a result of collectively bargained changes, your Plan's out-of-pocket limits are lower than those required under federal PPACA provisions. Limits are determined annually by negotiated benefit changes.

Out-of-Pocket Limit: The amount you pay for network services/supplies is capped at the out-of-pocket limit. Network expenses include copayments you make to providers, facilities and pharmacies (network expenses do not include premiums, deductibles or coinsurance). Once the out-of-pocket limit is reached, network benefits are paid in full.

Effective January 1, 2025, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $2,670 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $1,450 for in-network expenses incurred under the Prescription Drug Program*

Family Coverage

- $5,350 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $2,890 for in-network expenses incurred under the Prescription Drug Program*

**** Does not apply to Medicare-primary enrollees or Medicare-primary dependents. Refer to your Empire Plan Medicare Rx documents for information about your out-of-pocket expenses.***

Out-of-Network Combined Annual Deductible

The combined annual deductible is $1,250 for the enrollee, $1,250 for the enrolled spouse/domestic partner and $1,250 for all dependent children combined. Each deductible amount will be reduced to $625 per calendar year for employees in titles equated to salary grade level six or below.

The combined annual deductible must be met before the following expenses will be considered for reimbursement: (1) Basic Medical Program expenses, (2) non-network expenses under the Home Care Advocacy Program or (3) non-network outpatient expenses under the Mental Health and Substance Use Program.

Combined Annual Coinsurance Maximum

The combined annual coinsurance maximum is $3,750 for the enrollee, $3,750 for the enrolled spouse/domestic partner and $3,750 for all dependent children combined. Each coinsurance maximum will be reduced to $1,875 per calendar year for employees in titles equated to salary grade level six or below.

Coinsurance amounts incurred for non-network Hospital Program coverage, Basic Medical Program coverage and non-network Mental Health and Substance Use Program coverage count toward the combined annual coinsurance maximum. Copayments to Medical/Surgical Program participating providers and to Mental Health and Substance Use Program network practitioners also count toward the combined annual coinsurance maximum. (**Note:** Copayments made to network facilities do not count toward the combined annual coinsurance maximum.)

Preventive Care Services

Your Empire Plan benefits include provisions for expanded coverage of preventive health care services required by the federal Patient Protection and Affordable Care Act (PPACA).

When your participating provider recommends preventive care services for you that meet PPACA federally established criteria (such as age, gender and risk factors), those preventive services are provided to you at no cost when you use an Empire Plan participating provider or network facility. See the *2025 Empire Plan Preventive Care Coverage Guide* for a list of covered services.

For further information, visit www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html.

Center of Excellence Programs

For further information on any of the programs listed below, refer to your *Empire Plan Certificate* and the publication *Reporting On Center of Excellence Programs.* In some cases, a travel, lodging and meal allowance may be available. If you do not use a Center of Excellence, benefits are provided in accordance with Hospital, Medical/Surgical and/or Mental Health and Substance Use Program coverage.

Cancer Services*

You must call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 19) or call the Cancer Resource Services (CRS) toll free at 1-866-936-6002 and register to participate

Paid-in-full benefits are available for the following cancer services provided at a CRS-contracted Center of Excellence:

- Inpatient and outpatient hospital and physician care related to the cancer treatment, including laboratory and radiology services.
- Cancer clinical trials and related treatments and services. These treatments and services must be recommended and provided by a physician in a cancer center. The cancer center must be a participating facility in the CRS network at the time the treatment or service is provided.

You will also have access to nurse consultants who will answer your questions and help you understand your cancer diagnosis, assistance locating designated cancer centers and a travel allowance, when applicable.

Transplants Program*

You must call The Empire Plan and choose the Hospital Program (see *Contact Information*, page 19) for prior authorization

Paid-in-full benefits are available for the following transplant services when authorized by the Hospital Program and received at a designated Center of Excellence or a Blue Cross Blue Shield Association's Blue Distinction Centers for Transplants: pretransplant evaluation of transplant recipient; inpatient and outpatient hospital and physician services; and up to 12 months of follow-up care.

You must call The Empire Plan for preauthorization of the following transplants provided through the Center of Excellence for Transplants Program: bone marrow, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell and simultaneous kidney/pancreas. When applicable, a travel allowance is available. If you choose to have your transplant in a facility other than a designated Center of Excellence (or if you require a small bowel or multivisceral transplant) you may still take advantage of the Hospital Program case management services, in which a nurse will help you through the transplant process, if you enroll in the Center of Excellence for Transplants Program. If a transplant is authorized but you do not use a designated Center of Excellence, benefits will be provided in accordance with Hospital and/or Medical/Surgical Program coverage. **Note:** Transplant surgery preauthorization is required whether or not you choose to participate in the Center of Excellence for Transplants Program.

Infertility Benefits*

PRESS OR SAY 1

Call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 19) for predetermination

Paid-in-full benefits are available, subject to the lifetime maximum for Qualified Procedures ($50,000 per covered person) including any applicable travel allowance, when you choose a Center of Excellence for Infertility. To request a list of Qualified Procedures, verify coverage of infertility benefits or to find out how using a Center of Excellence offers you the highest level of benefits available for infertility care, call the Medical/Surgical Program.

The lifetime maximum applies to all covered hospital, medical, travel, lodging and meal expenses associated with the Qualified Procedure. If three in vitro fertilization (IVF) cycles have not been completed once the $50,000 lifetime maximum is reached, the Plan will cover the remaining IVF cycles until three have been met, including the associated travel, lodging and meal expenses.

** Program requirements apply even if Medicare or another health plan is primary to The Empire Plan.*

Substance Use Disorder Services

You must call The Empire Plan and press or say 3 to reach the Mental Health and Substance Use Program (see *Contact Information*, page 19) for preauthorization

Paid-in-full benefits are available for substance use disorder treatment when received at a Center of Excellence through the Hazelden Betty Ford Foundation for the following services when prior authorization is obtained: detox, residential, partial hospitalization (with boarding) and intensive outpatient. Authorized benefits include assessment prior to treatment, full evaluation at the provider site, care coordination for transition back to home community, children's support program for those age seven to 12 impacted by addiction and family treatment and support, including individual virtual support services. When applicable, a travel, lodging and meal allowance is available. The travel allowance will include coverage for up to two companions, regardless of the patient's age. To participate in the Center of Excellence, The Empire Plan must be your primary insurance coverage.

Center of Excellence Program Travel Allowance

When you are enrolled in the Center of Excellence Program or use a Center of Excellence for preauthorized infertility services, a travel, lodging and meal expenses benefit is available for travel within the United States. The benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, it will include coverage for up to two companions. If you are enrolled in the Substance Use Disorder Program, the travel benefit provides coverage for up to two companions, regardless of the patient's age. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the U.S. General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. Once you arrive at your lodging and need transportation from your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

Hospital Program

PRESS OR SAY 2 Call The Empire Plan and press or say 2 to reach the Hospital Program (see *Contact Information*, page 19)

The Hospital Program provides benefits for services provided in a network or non-network inpatient or outpatient hospital, skilled nursing facility or hospice setting. Services and supplies must be covered and medically necessary, as defined in the current version of your *Empire Plan Certificate* or as amended in subsequent *Certificate Amendments.* The Medical/Surgical Program provides benefits for certain medical and surgical care when it is not covered by the Hospital Program. Call the Hospital Program for preadmission certification or if you have questions about your benefits, coverage or an Explanation of Benefits statement. Network coverage applies when you receive emergency or urgent services in a non-network hospital, or when you use a non-network hospital because you do not have access to a network hospital. Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Network Coverage

You pay only applicable copayments for services/supplies provided by a hospital, skilled nursing facility or hospice that is part of The Empire Plan network. No deductible or coinsurance applies. Network coverage also applies when The Empire Plan provides coverage that is secondary to other coverage.

Non-Network Coverage

When you use a facility that is not part of The Empire Plan network and do not qualify for network coverage (see above), your out-of-pocket costs are higher.

- You are responsible for a coinsurance amount of 10 percent of billed charges for inpatient facility services until you meet the combined annual coinsurance maximum
- You are responsible for a coinsurance amount of either 10 percent of billed charges or a $75 copayment, whichever is greater, for outpatient services until you meet the combined annual coinsurance maximum

Hospital Inpatient

You must call for preadmission certification (see page 2)

The Hospital Program covers you for a combined maximum of up to 365 days per spell of illness for inpatient diagnostic and therapeutic services or surgical care provided by a network and/or non-network hospital. Inpatient hospital coverage is provided under the Medical/Surgical Program's Basic Medical Program after Hospital Program benefits end.

Network Coverage

Inpatient stays in a network hospital are paid in full.

Non-Network Coverage

Inpatient stays in a non-network hospital are subject to a coinsurance amount of 10 percent of billed charges, until you meet the combined annual coinsurance maximum (see page 3). Network coverage is provided once the combined annual coinsurance maximum is satisfied.

Hospital Outpatient

Emergency Department

Network Coverage

You pay one $100 copayment per visit to an emergency department, including use of the facility for emergency care, services of the attending physician, services of providers who administer or interpret laboratory tests and electrocardiogram services. Other physician charges are covered under the Medical/Surgical Program (see page 7).

The copayment is waived if you are admitted as an inpatient directly from the emergency department.

Non-Network Coverage

Network coverage applies to emergency services received in a non-network hospital.

Outpatient Department or Hospital Extension Clinic

The hospital outpatient services covered under the Program are the same whether received in a network or non-network hospital outpatient department or in a network or non-network hospital extension clinic. The following benefits apply to services received in the outpatient department of a hospital or a hospital extension clinic.

Network Coverage

Outpatient surgery is subject to a $95 copayment.

You pay one $50 copayment per visit for diagnostic radiology and diagnostic laboratory tests.

You have paid-in-full benefits for the following services: preadmission and/or presurgical testing prior to an inpatient admission, chemotherapy, radiation therapy, anesthesiology, pathology and dialysis.

The following services are paid-in-full when designated preventive according to the Patient Protection and Affordable Care Act: bone mineral density tests, colonoscopies, lung cancer screenings, mammograms,* pap smears, proctosigmoidoscopy screenings, prostate cancer screenings and sigmoidoscopy screenings.

Non-Network Coverage

You are responsible for a coinsurance amount of 10 percent of billed charges or a $75 copayment (whichever is greater) per visit, until you meet the combined annual coinsurance maximum (see page 3). Network coverage is provided once the combined annual coinsurance maximum is satisfied.

** Screening, diagnostic and 3-D mammograms are paid in full under New York State law.*

Network Coverage

Physical therapy following a related hospitalization or related inpatient or outpatient surgery is subject to a $25 copayment per visit. Physical therapy must start within six months of your discharge from the hospital or the date of your outpatient surgery and be completed within 365 days from the date of hospital discharge or outpatient surgery.

Medically necessary physical therapy is covered under the Managed Physical Medicine Program when not covered under the Hospital Program (see page 12).

Site of Care Program for Infusions

If you are or will be receiving infusion therapies, except those used to treat cancer or hemophilia, in the outpatient hospital setting, the Hospital Program will determine if the outpatient hospital setting is clinically appropriate for your infusions. If the outpatient hospital setting is not clinically appropriate, the Hospital Program will work with your doctor and the Medical/Surgical Program to find an alternate setting for your infusion therapy, which can include a freestanding infusion suite, your doctor's office or your home. If your infusion is transitioned, the Medical/Surgical Program and Prescription Drug Program copayments for your infusion therapy will be waived. To participate in the Program, The Empire Plan must be your primary insurance coverage. For the most up-to-date Site of Care Program for Infusions Drug List, go to www.anthembluecross.com/nys and choose Plans and then Resources & Forms.

Medical/Surgical Program Benefits for Physician/Provider Services Received in a Hospital Inpatient or Outpatient Setting

When you receive covered services from a physician or other provider in a hospital, and those services are billed by the provider (not the facility), the following Medical/Surgical Program benefits apply:

Participating Provider Program
Covered services are paid with no cost to you when the provider participates in The Empire Plan network.

Basic Medical Program
If you receive services in connection with covered inpatient or outpatient services at an Empire Plan network hospital and The Empire Plan provides your primary coverage, covered charges billed separately for anesthesiology, pathology, radiology and neonatology; care provided by assistant surgeons, hospitalists and intensivists; and diagnostic services (including radiology and laboratory services) will be paid with no cost to you by the Medical/Surgical Program. Services provided by other nonparticipating providers are subject to deductible and coinsurance.

Emergency care in a hospital emergency department and inpatient services resulting from an emergency admission are covered as follows:

- An attending emergency department physician is paid with no cost to you
- Participating or nonparticipating providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams and/or pathology are paid with no cost to you
- Other participating providers are paid with no cost to you
- Other nonparticipating providers (e.g., surgeons) are paid with no cost to you

The Empire Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from nonparticipating (non-network) providers at a network facility without their knowledge. See *Out-of-Network Reimbursement Disclosures* or contact the Medical/Surgical Program for more information.

Skilled Nursing Facility Care

You must call for preadmission certification
(see page 2)

Benefits are subject to the requirements of the Empire Plan Benefits Management Program if The Empire Plan provides your primary health coverage. Does not apply to Medicare-primary enrollees or Medicare-primary dependents.

Network Coverage

Skilled nursing facility care is paid in full when provided in place of hospitalization. Limitations apply; refer to your *Empire Plan Certificate* regarding conditions of coverage.

Non-Network Coverage

Skilled nursing facility care is covered when provided in place of hospitalization. You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum. Network coverage is provided once the combined annual coinsurance maximum is satisfied (see page 3).

Hospice Care

Network Coverage

Care provided by a licensed hospice program is paid in full. Enrollees are eligible for hospice care if the doctor and hospice medical director certify that the covered patient is terminally ill and likely has less than 12 months to live. Refer to your *Empire Plan Certificate* regarding conditions of coverage.

Non-Network Coverage

You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum, for care provided by a licensed hospice program. Network coverage is provided once the combined annual coinsurance maximum is satisfied (see page 3).

Medical/Surgical Program

PRESS OR SAY 1 Call The Empire Plan and press or say 1 to reach the Medical/Surgical Program
(see *Contact Information*, page 19)

The Medical/Surgical Program covers services received from a physician or other practitioner licensed to provide medical/surgical services. It also covers services received from facilities not covered under the Hospital Program, such as outpatient surgical centers, imaging centers, laboratories, cardiac rehabilitation centers, urgent care centers and convenience care clinics. Services and supplies must be covered and medically necessary, as defined in the current version of your *Empire Plan Certificate* or as amended in subsequent *Certificate Amendments*. Call the Medical/Surgical Program if you have questions about coverage, benefits or the status of a provider.

Participating Provider Program

The Participating Provider Program provides medical/surgical benefits for services/supplies received from a provider that participates in The Empire Plan network. Always ask your provider if they are a participating provider and accepting new patients before you receive services. To find a participating provider in the expanded network, go to the NYSHIP website at www.cs.ny.gov/employee-benefits. You may also call the Medical/Surgical Program and a representative can assist you with locating a provider.

When you receive covered services from a participating provider, you pay only applicable copayments. Women's health care services, many preventive care services and certain other covered services are paid in full (see pages 10–12).

Guaranteed Access

The Empire Plan will guarantee access to Participating Provider Program benefits for primary care providers and certain specialists when there are no Empire Plan participating providers within a reasonable distance from the enrollee's residence. This benefit is available in New York State and counties in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont that share a border with New York State. To receive this benefit:

- The Empire Plan must provide your primary health coverage (pays first, before another health plan or Medicare).

- You must contact the Medical/Surgical Program prior to receiving services and use one of the providers approved by the Program.
- You must contact the provider to arrange care. Appointments are subject to provider's availability and the Program does not guarantee that a provider will be available in a specified time period.

For information about the mileage standards used to define reasonable distance and the primary care providers and core specialties included in this benefit, call the Medical/Surgical Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits. Guaranteed access provisions can be found in the *Empire Plan Certificate* under *Participating Provider Program* in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*.

The Empire Plan provides additional protections to ensure enrollees have access to primary care and specialty providers. See *Out-of-Network Reimbursement Disclosures* or contact the Medical/Surgical Program for more information.

Basic Medical Program

The Basic Medical Program provides benefits for services/supplies received from a provider that does not participate in The Empire Plan network. Your out-of-pocket costs are higher when you use a nonparticipating provider.

Combined annual deductible: The combined annual deductible must be satisfied before The Empire Plan reimburses for benefits received from a nonparticipating provider (see page 3).

Coinsurance: The Empire Plan reimburses 80 percent of the allowed amount for covered services after you meet the combined annual deductible. You are responsible for the balance.

Combined annual coinsurance maximum: After the combined annual coinsurance maximum is reached, The Empire Plan reimburses 100 percent of the allowed amount for covered services (see page 3).

Basic Medical Provider Discount Program

If The Empire Plan is your primary insurance coverage and you use a nonparticipating provider who is part of The Empire Plan MultiPlan group, your out-of-pocket expense will, in most cases, be reduced. Your share of the cost will be based on the lesser of The Empire Plan MultiPlan fee schedule or the allowed amount.

The Empire Plan MultiPlan provider will submit bills to and receive payments directly from UnitedHealthcare. You are only responsible for the applicable deductible and coinsurance amounts. To find a provider, call the Medical/Surgical Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits.

Allowed Amount

The allowed amount for nonparticipating providers is determined by the Medical/Surgical Program Administrator (currently UnitedHealthcare) as follows:

- Allowed amounts are determined based on 275 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
- When a rate is not published by CMS for the service, an available gap methodology as determined by the Medical/Surgical Program Administrator is used to produce a rate for the service.
  - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the allowed amount is based on 20 percent of the provider's billed charge.

The allowed amount for nonparticipating providers generally equates to 50 percent of FAIR Health® Usual and Customary professional rates.* FAIR Health® is a nonprofit organization approved by the State of New York as a benchmarking database. To determine the usual and customary rate for these services in your geographic area or ZIP code, you can visit www.fairhealthconsumer.org.

You can estimate the anticipated out-of-pocket cost for nonparticipating provider services by contacting your provider for the amount that will be charged and then visiting www.myuhc.com to obtain a cost estimate.

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health® rates.*

IMPORTANT NOTICE: Nonparticipating providers may bill you for any difference between the provider's billed charges and the allowed amount described here. This includes facility-based, nonancillary services when notice and consent is satisfied as described under section 2799B-2(d) of the Public Health Service Act.

Office Visit/Office Surgery, Laboratory/Radiology and Contraceptives

Participating Provider Program

Office visits, including office surgery, laboratory services, radiology services and/or certain immunizations, may be subject to a single $25 copayment per visit to a provider. The costs of U.S. Food and Drug Administration (FDA)-approved contraceptive methods for women, including sterilization, that require physician intervention, are covered and are not subject to a copayment. Vasectomies are covered subject to copayment. Certain visits and laboratory/radiology services are not subject to copayment, including well-child care, prenatal care and visits for preventive care and women's health care. Screening, diagnostic and 3-D mammograms are paid in full under New York State law.

Basic Medical Program

Covered services provided by or received from a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Urgent Care

Participating Provider Program

Services and visits for urgent care may be subject to a $30 copayment. You pay a maximum of two copayments per visit. Urgent care services and visits at a hospital-owned facility are subject to a $50 copayment.

Basic Medical Program

Covered services provided by or received from a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Routine Health Exams

Participating Provider Program

Preventive routine health exams are paid in full.

Other covered non-preventive services received during a routine health exam may be subject to copayment(s).

Basic Medical Program

Routine health exams are covered for active employees age 50 or older and for an active employee's spouse/domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance. Covered services, such as laboratory tests and screenings provided during a routine exam that fall outside the scope of a routine exam, are subject to deductible and coinsurance. For further information, contact the Medical/Surgical Program.

Adult Immunizations

Participating Provider Program

The following adult immunizations are covered at no cost to you, based on recommendations by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC):*

- COVID-19; Hepatitis A; Hepatitis B; Herpes zoster (shingles); Human papillomavirus (HPV); Influenza (flu); Measles, mumps, rubella; Meningococcal (meningitis); Mpox; Pneumococcal (pneumonia); Respiratory syncytial virus (RSV); Tetanus, diphtheria, pertussis; Varicella (chickenpox)

Doses, recommended ages and populations vary. Other immunizations may be subject to a copayment. No copayment is required for enrollees and dependents age 19 and older for Herpes zoster (shingles).**

Basic Medical Program

Not covered.

** Paid in full under the Prescription Drug Program at all CVS Caremark National Vaccine Network Pharmacies, subject to age limitations and CDC guidelines. See page 18 for vaccinations covered under the Prescription Drug Program.*

*** A prescription may be required for enrollees age 19–49.*

Routine Pediatric Care • *Up to age 19*

Participating Provider Program

Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and the cost of oral and injectable substances when administered according to pediatric immunization guidelines.

Basic Medical Program

Routine newborn child care: Provider services for routine care, including immunizations, of a newborn child are covered and not subject to deductible or coinsurance.

Routine pediatric care: Routine pediatric care, including immunizations, provided by a nonparticipating provider is subject to Basic Medical Program benefits, including deductible and coinsurance.

Outpatient Surgical Locations

Participating Provider Program

A $50 copayment covers facility, same-day on-site testing, laboratory services provided on-site and anesthesiology charges for covered services at a participating outpatient surgical center.

Basic Medical Program

Covered services provided by a nonparticipating outpatient surgical center are subject to Basic Medical Program benefits, including deductible and coinsurance.

Hospital and hospital-based outpatient surgical locations are covered under the Hospital Program (see *Outpatient Department or Hospital Extension Clinic*, page 6).

Diabetes Education Centers

Participating Provider Program

Visits to a Diabetes Education Center are subject to a $25 copayment.

Basic Medical Program

Visits to a nonparticipating Diabetes Education Center are subject to Basic Medical Program benefits, including deductible and coinsurance.

Prostheses and Orthotic Devices

Participating Provider Program

Prostheses/orthotic devices that meet the individual's functional needs are paid in full when obtained from a participating provider.

Basic Medical Program

Prostheses/orthotic devices that meet the individual's functional needs are subject to Basic Medical Program benefits, including deductible and coinsurance.

Hearing Aids

Basic Medical Program

Hearing aids, when prescribed by a licensed provider, including evaluation, fitting and purchase, are covered under the Basic Medical Program, up to a maximum reimbursement of $1,500 per hearing aid, per ear, once every four years. Children age 12 and under are covered up to $1,500 per hearing aid, per ear, once every two years if the existing hearing aid can no longer compensate for the child's hearing loss. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

Wigs

Basic Medical Program

Wigs are covered under the Basic Medical Program benefit, up to a $1,500 lifetime maximum, when hair loss is due to a chronic or acute medical condition. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

Mastectomy Bras and External Mastectomy Prostheses

Participating Provider and Basic Medical Programs

Mastectomy bras are covered at no cost. One single or double external mastectomy prosthesis is covered under the Basic Medical Program, once per calendar year. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance. You must call the Medical/Surgical Program and select the Home Care Advocacy Program for precertification of any single prosthesis costing $1,000 or more. For a prosthesis requiring prior approval, benefits will be available for the most cost-effective prosthesis that meets an individual's functional needs.

Gender Affirmation Treatment

Participating Provider and Basic Medical Programs

Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery and other associated surgeries, services and procedures, including those to change your physical appearance to more closely conform secondary sex characteristics to those of your identified gender, are covered when your behavioral health provider completes a determination of medical necessity.

Emergency Ambulance Service

Basic Medical Program

Local commercial ambulance transportation is a covered basic medical expense subject only to a $70 copayment. Volunteer ambulance transportation will continue to be reimbursed for donations at the current rates of $50 for under 50 miles and $75 for over 50 miles. This benefit applies whether you use an ambulance service that is a participating provider or a nonparticipating provider and is not subject to deductible or coinsurance.

Managed Physical Medicine Program

Administered by Managed Physical Network (MPN)

Chiropractic Treatment, Physical Therapy and Occupational Therapy

Network Coverage

Each office visit to a network provider, including related radiology and diagnostic laboratory services, is subject to a single $25 copayment. No more than one copayment per visit will be assessed.

MPN guarantees access to network benefits. If there are no network providers in your area, you must contact MPN prior to receiving services to arrange for network benefits. Therapy must be prescribed by a qualified provider.

Non-Network Coverage

Annual deductible: $250 enrollee; $250 enrolled spouse/domestic partner; $250 all dependent children combined. This deductible is separate from the combined annual deductible.

Coinsurance: The Empire Plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum. Coinsurance under the Managed Physical Medicine Program does not contribute to and is separate from the combined annual coinsurance maximum. The network allowance generally equates to 13 percent of FAIR Health® Usual and Customary professional rates.*

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health® rates.*

Home Care Advocacy Program (HCAP)

Home Care Services, Skilled Nursing Services and Durable Medical Equipment/Supplies

You must call
for prior authorization

Network Coverage *(when you use HCAP)*

To receive a paid-in-full benefit, you must call The Empire Plan to precertify and help make arrangements for covered services provided in the home (e.g., skilled nursing, home infusion), durable medical equipment and supplies, including one pair of diabetic shoes per year, insulin pumps and enteral formulas. Diabetic shoes have an annual maximum benefit of $500.

Exceptions: For diabetic supplies (except insulin pumps), call The Empire Plan Diabetic Supplies Pharmacy at 1-800-321-0591. Certain diabetic supplies are covered in full when obtained at a network pharmacy. If you are Medicare-primary, be sure to use a provider who participates with Medicare to ensure the highest level of benefits. For ostomy supplies, call Byram Healthcare Centers at 1-800-354-4054.

Non-Network Coverage *(when you don't use HCAP)*

The first 48 hours of nursing care are not covered. After you meet the combined annual deductible (see page 3), The Empire Plan pays up to 50 percent of the HCAP network allowance for covered services provided in the home (e.g., skilled nursing, home infusion), durable medical equipment and supplies. There is no coinsurance maximum. You are also covered for one pair of diabetic shoes per year that are paid up to 75 percent of the HCAP network allowance with a $500 annual maximum. The network allowance generally equates to 32 percent of FAIR Health® Usual and Customary professional rates.*

Covered home skilled nursing services do not include assistance with activities of daily living, custodial care or any other service that can be given by a less skilled person, such as a home health aide.

Important: If Medicare is your primary coverage and you do not use a Medicare contract provider, your benefits will be reduced. If you are in an area that participates in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, you must use a Medicare-approved supplier. To locate a Medicare contract supplier, visit www.medicare.gov/medical-equipment-suppliers/ or contact The Empire Plan.

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health® rates.*

Mental Health and Substance Use Program

PRESS OR SAY 3 **For the highest level of benefits, call The Empire Plan and press or say 3 to reach the Mental Health and Substance Use Program (see *Contact Information*, page 19)**

To receive the highest level of benefits you must call the Mental Health and Substance Use (MHSU) Program before seeking services from a mental health or substance use care provider. This includes services that require precertification to confirm medical necessity before starting treatment (see list on page 14). Call The Empire Plan and press or say 3 to reach the Mental Health and Substance Use Program. You can reach the Clinical Referral Line by selecting option 3 from the MHSU Program menu. The Clinical Referral Line is available 24 hours a day, every day of the year. In an emergency, go to the nearest hospital emergency department. You or your designee should call the Mental Health and Substance Use Program within 48 hours of an admission for emergency care or as soon as reasonably possible.

To check if providers or facilities are in The Empire Plan network, visit the NYSHIP website at www.cs.ny.gov/employee-benefits. Choose your group and plan, if prompted, and select Find an Empire Plan Provider. Under the MHSU Program, click on the ReferralConnect link. On ReferralConnect you can search for a specific provider or provider type in your area. If there are no network providers in your area, you have guaranteed access to network level benefits if you call the Clinical Referral Line to arrange your care with an appropriate provider.

Schedule of Benefits for Covered Services

The Program Administrator must certify all covered services as medically necessary, regardless of whether you are using network or non-network coverage. If the Program Administrator does not certify your inpatient or outpatient treatment as medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

The following services require Precertification from the Program Administrator:

- Intensive outpatient program for mental health
- Structured outpatient program for substance use disorder*
- 23-hour bed for mental health or substance use disorder
- 72-hour bed for mental health or substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavioral Analysis (ABA)
- Group home
- Halfway house
- Residential treatment center for mental health**
- Residential treatment center for substance use disorder*
- Partial hospitalization for mental health
- Partial hospitalization for substance use disorder*

** Precertification is not required for OASAS-certified Network Facilities located within New York State.*

*** Precertification is not required for covered individuals under 18 years of age at OMH-certified Network Facilities located within New York State.*

Network Coverage

You pay only applicable copayments for covered services provided by a provider or facility that is in The Empire Plan network. No deductible or coinsurance applies.

Non-Network Coverage

When you use a provider or facility that is not in The Empire Plan network, your out-of-pocket costs are higher, as described in this section.

Inpatient Services

You should call before an admission to a mental health or substance use care facility to ensure that benefits are available. In the case of an emergency admission, certification should be requested as soon as possible. Network facilities are responsible for obtaining precertification. If you use a non-network facility, you may be required to pay the full cost of any stay determined not to be medically necessary.

Network Coverage	Non-Network Coverage
Inpatient stays in an approved network facility are paid in full.	You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum (see page 3). When the combined annual coinsurance maximum is met, you will receive network benefits.
Practitioner treatment or consultation: Covered treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner — not the facility — are paid in full.	**Practitioner treatment or consultation:** Covered treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner — not the facility — are subject to deductible and coinsurance as described under *Office Visits and Other Outpatient Services* (see page 15).

Ambulance Service

Ambulance service to a facility where you will be receiving mental health or substance use care is covered at no cost to you when medically necessary. When the enrollee has no obligation to pay, donations up to $50 for trips of fewer than 50 miles and up to $75 for trips over 50 miles will be reimbursed for voluntary ambulance services. This benefit is not subject to deductible or coinsurance.

Outpatient Services

Hospital Emergency Department

Network Coverage

You pay one $100 copayment per visit to an emergency department. The copayment is waived if you are admitted as an inpatient directly from the emergency department.

Non-Network Coverage

Network coverage applies to emergency department visits at a non-network hospital.

Office Visits and Other Outpatient Services

Network Coverage

Office visits and other outpatient services, such as outpatient substance use rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a $25 copayment per visit.

Up to three visits per crisis are paid in full for mental health care treatment. After the third visit, the $25 copayment per visit applies.

Non-Network Coverage

Combined annual deductible: Must be satisfied before The Empire Plan pays benefits (see page 3).

Coinsurance: The Empire Plan pays 80 percent of the allowed amount for covered services after you meet the combined annual deductible. You are responsible for the balance.

Combined annual coinsurance maximum: After the combined annual coinsurance maximum is reached, the Plan pays benefits for covered services at 100 percent of the allowed amount (see page 3).

Allowed Amount: Determined based on 275 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. You can estimate the anticipated out-of-pocket cost for nonparticipating provider services by contacting the Carelon Behavioral Health customer service team. Call 1-877-769-7447 and press or say 3 to speak to a representative.

Prescription Drug Program

PRESS OR SAY 4 Call The Empire Plan and press or say 4 to reach the Prescription Drug Program (see *Contact Information*, page 19)

The Prescription Drug Program provides coverage for prescriptions for covered drugs, up to a 90-day supply, when filled at network, mail service, specialty and non-network pharmacies.

Copayments

You have the following copayments for covered drugs purchased from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy.

Drug Category	Up to a 30-day Supply from a Network Pharmacy, the Mail Service Pharmacy or the Designated Specialty Pharmacy	31- to 90-day Supply from a Network Pharmacy	31- to 90-day Supply from the Mail Service Pharmacy or the Designated Specialty Pharmacy
Level 1 Drugs or for Most **Generic** Drugs	$5	$10	$5
Level 2 Drugs, **Preferred** Drugs or Compound Drugs	$30	$60	$55
Level 3 Drugs or **Non-Preferred** Drugs	$60	$120	$110

Drugs Not Subject to Copayment

Certain covered drugs do not require a copayment when using a network pharmacy:

- Oral chemotherapy drugs, when prescribed for the treatment of cancer
- Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices), with up to a 12-month supply of contraceptives at one time without an initial 3-month supply
- Medications used for emergency contraception and pregnancy termination
- Tamoxifen, raloxifene (for patients age 35 and over), anastrozole and exemestane, when prescribed for the primary prevention of breast cancer
- Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), when prescribed for enrollees who are at high risk of acquiring HIV
- Certain preventive adult vaccines when administered by a licensed pharmacist at a pharmacy that participates in the CVS Caremark national vaccine network
- Certain prescription and over-the-counter medications* that are recommended for preventive services without cost sharing and have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF)

** When available over-the-counter, USPSTF "A" and "B" rated medications require a prescription order to process without cost sharing.*

Brand-Name Drugs with Generic Equivalent

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the non-preferred drug copayment plus the ancillary charge, not to exceed the full retail cost of the covered drug.

Ancillary Charge: The difference in cost between the brand-name drug and the generic equivalent.

Exceptions

- If the brand-name drug has been placed on Level 1 of The Empire Plan Advanced Flexible Formulary, you will pay the Level 1 copayment.
- You pay only the applicable copayment for the following brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. One copayment covers up to a 90-day supply. Most of these drugs will have non-preferred copayments with no ancillary fee charged.

Advanced Flexible Formulary Drug List

The Empire Plan Prescription Drug Program has a flexible formulary drug list for prescription drugs. The Empire Plan Advanced Flexible Formulary is designed to provide enrollees and the Plan with the best value in prescription drug spending. This is accomplished by:

- Excluding coverage for certain brand-name or generic drugs if the drug has no clinical advantage over other covered medications in the same therapeutic class.
- Placing a brand-name drug on Level 1 or excluding or placing a generic drug on Level 3, subject to the appropriate copayment. These placements may be revised mid-year when such changes are advantageous to The Empire Plan. Enrollees will be notified in advance of such changes.
- Applying the highest copayment to non-preferred drugs that provide no clinical advantage over two or more Level 1 drug alternatives in the same therapeutic class. This may result in no Level 2 brand-name drugs.
- Including utilization management tools to promote transparency and reduce costs, not limited to generic substitution, prior authorization and physician education.

For the most up-to-date version, please visit the NYSHIP website at www.cs.ny.gov/employee-benefits.

Prior Authorization Drugs

You must have prior authorization for certain drugs, including generic equivalents, noted with "PA" on the Empire Plan Advanced Flexible Formulary.

Certain medications also require prior authorization based on age, gender or quantity limit specifications. Compound drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization.

The drugs that require prior authorization are subject to change quarterly as drugs are approved by the U.S. Food and Drug Administration (FDA), introduced into the market or approved for additional indications. For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits.

Excluded Drugs

Certain brand-name and generic drugs are excluded from The Empire Plan Advanced Flexible Formulary if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2025 Empire Plan Advanced Flexible Formulary identifies drugs that are excluded in 2025, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. For a complete list of Excluded Drugs, call the Prescription Drug Program or go to the NYSHIP website.

Medical Exception Program for Excluded Drugs

A Medical Exception Program* is available for non-formulary drugs that are excluded from coverage.

To request a medical exception, you and your physician must first evaluate whether covered drugs on the Advanced Flexible Formulary are appropriate alternatives for your treatment. After an appropriate trial of formulary alternatives, your physician may submit a letter of medical necessity to CVS Caremark that details the formulary alternative trials and any other clinical documentation supporting medical necessity. The physician can fax the exception request to CVS Caremark at 1-888-487-9257.

** If you are Medicare-primary, refer to your Empire Plan Medicare Rx plan materials for information regarding your appeal rights and the process to follow.*

If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment will apply for non-preferred brand-name drugs.

Note: Drugs that are only FDA-approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

Dispense as Written (DAW) Exception Request

When your doctor writes your prescription as DAW for a non-preferred brand-name drug that has a generic equivalent, you pay the non-preferred (Level 3) copayment plus the ancillary charge, not to exceed the full retail cost of the drug. If 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 (Level 1) copayment.

If your doctor believes it is medically necessary for you to have a non-preferred brand-name drug (that has a generic equivalent), your doctor must submit a DAW Exception Request form (available at www.caremark.com) or call The Empire Plan to request an exception.

If your DAW Exception Request is granted and you fill your prescription for a non-preferred brand-name drug at a Network Pharmacy or through a Mail Service Pharmacy or the Designated Specialty Pharmacy, you pay only the non-preferred (Level 3) copayment. You will not have to pay the ancillary charge. If your DAW Exception Request is denied, you may appeal to CVS Caremark.

If your appeal is approved, the pharmacy will either reverse and reprocess the claim, or the pharmacy will work with CVS Caremark to allow a new claim to be processed with the approved exception so that the ancillary charge is not applied.

Types of Pharmacies

Network Pharmacy

A network pharmacy is a retail pharmacy that participates in the CVS Caremark network. When you visit a network pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail network pharmacy location that participates in the CVS Caremark network, call the Prescription Drug Program or go to the NYSHIP website at www.cs.ny.gov/employee-benefits.

CVS Caremark National Vaccine Network Pharmacy

Select preventive vaccines are covered without copayment when administered at a pharmacy that participates in the CVS Caremark national vaccine network. Vaccines available in a pharmacy are:

- COVID-19
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Herpes zoster (shingles)*
- Human papillomavirus (HPV)
- Inactivated poliovirus (polio)
- Influenza (flu)
- Measles, mumps, rubella
- Meningococcal (meningitis)
- Mpox
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Rotavirus
- Tetanus, diphtheria, pertussis
- Varicella (chickenpox)

Certain vaccines have age limitations and follow the recommendations by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Only certain pharmacies are part of the CVS Caremark national vaccine network. To find out if a pharmacy participates in the CVS Caremark national vaccine network, call the Prescription Drug Program or visit www.empireplanrxprogram.com and select CVS Caremark, then Find a Local Pharmacy. Be sure to select Vaccine network under Advanced Search. Call the pharmacy in advance to verify availability of the vaccine.

** Shingrix® is covered for individuals 19 and older at no copayment. A prescription may be required for enrollees age 19–49.*

Mail Service Pharmacy

You may request that your prescriber send your prescription to the CVS Caremark Mail Service Pharmacy. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone, online at www.empireplanrxprogram.com or download forms on the NYSHIP website at www.cs.ny.gov/employee-benefits.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services, including:

- Refill reminder calls
- Expedited, scheduled delivery of your medications at no additional charge
- All necessary supplies, such as needles and syringes applicable to the medication at no additional cost
- Disease education
- Drug education
- Compliance management
- Side-effect management
- Safety management

Prior authorization is required for many specialty medications. To get started with the CVS Caremark Specialty Pharmacy, to request refills or to speak to a specialty-trained pharmacist or nurse, please call The Empire Plan Monday through Friday between 7:30 a.m. and 9 p.m., Eastern time. Choose the Prescription Drug Program and ask to speak with Specialty Customer Care. If your call is urgent, you may request an on-call pharmacist 24 hours a day, seven days a week. The list of specialty medications included in the Specialty Pharmacy Program is available on the NYSHIP website at www.cs.ny.gov/employee-benefits.

Non-Network Pharmacy

If you do not use a network pharmacy, or if you do not use your Empire Plan benefit card at a network pharmacy, you must submit a claim for reimbursement to: The Empire Plan Prescription Drug Program, c/o CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136.

In most cases, you will not be reimbursed the total amount you paid for the prescription.

- If your prescription was filled with a generic drug or a covered 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, less your copayment.
- If your prescription was filled with a covered 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, less your copayment, unless the brand-name drug has been placed on Level 1 of The Empire Plan Advanced Flexible Formulary.

Contact Information

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program.

PRESS OR SAY 1	**Medical/Surgical Program: *Administered by UnitedHealthcare*** Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time. TTY: 1-888-697-9054 P.O. Box 1600, Kingston, NY 12402-1600 Claims submission fax: 845-336-7716 Online submission: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Anthem Blue Cross*** Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Representatives are available Monday through Friday, 8 a.m. to 5 p.m., Eastern time. TTY: 711 New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 Claims submission fax: 866-829-2395 Online form: www.anthembluecross.com/nys/resources-forms
PRESS OR SAY 3	**Mental Health and Substance Use Program: *Administered by Carelon Behavioral Health*** Representatives are available 24 hours a day, seven days a week. TTY: 711 P.O. Box 1850, Hicksville, NY 11802 Claims submission fax: 855-378-8309 Online form: www.carelonbh.com/empireplan/en/home
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS Caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 711 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590
PRESS OR SAY 5	**Empire Plan NurseLine℠: *Administered by UnitedHealthcare*** Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.

Benefits on the Web

The NYSHIP website is a complete resource for your health insurance benefits, including:

- Current publications describing your benefits and plan
- Option Transfer materials, including a Plan Comparison Tool for NYSHIP options
- Announcements
- Resources
- Prescription drug information
- Contact information
- Links to all Empire Plan program administrator websites

To find the most up-to-date information about your health insurance coverage, go to **www.cs.ny.gov/employee-benefits**. Choose your group and plan, if prompted, to get to the NYSHIP website homepage.

This document provides a brief look at Empire Plan benefits for enrollees designated Management/Confidential; Legislature. Use it with your *Empire Plan Certificate* and *Empire Plan Reports*. If you have questions, call 1-877-7-NYSHIP (1-877-769-7447) and choose the program you need.

NEW YORK STATE | **Department of Civil Service**
New York State Health Insurance Program

New York State Department of Civil Service
Employee Benefits Division, Albany, New York 12239

518-457-5754 or 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
www.cs.ny.gov

The *Empire Plan At A Glance* is published by the Employee Benefits Division of the New York State 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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Department of Civil Service
New York State Health Insurance Program

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

M/C At A Glance – January 2025

It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the NYSHIP website at www.cs.ny.gov/employee-benefits. Visit the NYSHIP website for timely information that meets universal accessibility standards adopted by New York State for NYS agency websites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

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The Empire Plan Copayments at a Glance

The listed copayments apply when services are received under the Participating Provider Program or network coverage. Preventive care services under the Patient Protection and Affordable Care Act, women's health care services and certain other covered services are not subject to copayment.

Medical/Surgical Program	$25 copayment – Office visit, telehealth visit, office surgery, radiology, diagnostic laboratory tests, freestanding cardiac rehabilitation center visit, convenience care clinic visit $30 copayment – Urgent care center visit $50 copayment – Non-hospital outpatient surgical locations $70 copayment – Licensed ambulance service **Chiropractic treatment or physical therapy services (Managed Physical Medicine Program)** $25 copayment – Office visit, radiology, diagnostic laboratory tests
Hospital Program	$25 copayment – Outpatient physical therapy $50 copayment – Urgent care center visit, outpatient services for diagnostic radiology and diagnostic laboratory tests $95 copayment – Outpatient surgery $100 copayment – Emergency department visit
Mental Health and Substance Use Program	$25 copayment – Visit to an outpatient substance use treatment program $25 copayment – In-person or telehealth visit to a mental health professional $100 copayment – Emergency department visit
Prescription Drug Program	Up to a 90-day supply from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy (see copayment chart on page 15).