NEW YORK STATE | The Empire Plan

Empire Plan Certificate Amendments

Police Benevolent Association

For Troopers and Supervisors of the New York State Police represented by **Police Benevolent Association (PBA)**, their enrolled Dependents, COBRA Enrollees and Young Adult Option Enrollees

This document describes changes made to the January 1, 2019 Empire Plan Certificate.

January 1, 2021

New York State Department of Civil Service
Employee Benefits Division
www.cs.ny.gov/employee-benefits

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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 unrepresented 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.

Important Note: *Except where noted, the benefits described in this document are effective as of* ***January 1, 2021****.*

Throughout your Empire Plan Certificate*, update the Program's name from "*Mental Health and Substance Abuse (MHSA) Program*" to "*Mental Health and Substance Use (MHSU) Program*."*

Empire Plan Certificate of Insurance

Introduction

Replace the sixth bullet regarding the Managed Physical Medicine Program with the following:

- Managed Physical Medicine Program through UnitedHealthcare/Optum™ Physical Health, which includes Managed Physical Network, Inc. and OptumHealth Care Solutions, LLC, for chiropractic treatment, physical therapy and occupational therapy.

Add the following after the last paragraph:

Refer to your *Amendments* for changes that may occur to the out-of-network combined annual deductible, combined annual coinsurance maximum and copayments.

In-Network Out-of-Pocket Limit

Replace this section with the following:

Effective January 1, 2022, the annual out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,650 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $3,050 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Family Coverage

- $11,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $6,100 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Empire Plan Benefits Management Program

The following amendments apply to Plan documents for the Empire Plan Benefits Management Program.

Hospital, Skilled Nursing Facility and Medical/Surgical Benefits Management Program

You must call The Empire Plan and choose the Hospital Program for preadmission certification

Effective January 1, 2020, *Replace the first bullet with the following:*

- **If You are admitted to the hospital during Your pregnancy due to complications or for any reason other than the delivery of the baby.**

Add the following after the third bullet:

Effective January 1, 2020, You do not have to call before the birth of Your child; however, it is recommended 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.

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

A. Preadmission certification for hospital admission

Effective January 1, 2020, *Delete the second bullet under* **You must call**:

- Before the birth of a child.

Add the following paragraph after the third bullet:

Effective January 1, 2020, You do not have to call before the birth of Your child; however, it is recommended 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.

You pay a higher share of the cost if You do not follow the Empire Plan Benefits Management Procedures

Effective January 1, 2020, *Delete "*or an admission for the birth of a child*" from the first and third bullets.*

F. Future Moms Program

Replace the first and second sentences with the following:

The Future Moms Program is an Empire Plan Benefits Management Program that offers special help for pregnant women. This includes pregnant women acting as surrogates. To enroll, call The Empire Plan and choose the Hospital Program.

Future Moms Program

Replace this section with the following:

When Your primary coverage is The Empire Plan, You can sign up for the Future Moms Program—a pregnancy support program designed just for expectant moms. Participation in the Program is voluntary but recommended. The Benefits Management Program helps identify possible problems and works with mother and doctor throughout the pregnancy. This partnership can make a significant difference.

To enroll in the Future Moms Program, call The Empire Plan and choose the Hospital Program. Call as soon as You know You are pregnant (during the first month is best).

When You sign up for the Future Moms Program You receive:

- Your own maternal health coach.
- Access to a registered nurse helpline 24 hours a day, seven days a week.
- Helpful and informative materials throughout Your pregnancy on topics including Your baby's development and growth; fitness and nutrition; feeding Your baby; choosing the right doctor; and infant safety.
- Breastfeeding support from a lactation consultant, counselor or registered dietitian on LiveHealth Online.

Initial Assessment: A Benefits Management Program maternity registered nurse will ask You several easy questions such as, "Is this Your first pregnancy?" and "Have You had problems during previous pregnancies?" These questions can help determine if You or Your baby is at risk. The questions take a few minutes at the most, and Your answers are strictly confidential.

If You are identified as high risk, You can elect to participate in the High Risk Pregnancy Program. You will be contacted at least once a month by a Future Moms Program nurse for ongoing assessments. Your participation is voluntary, and calls will be scheduled at Your convenience.

Shortly after You join the Future Moms Program, You will receive a welcome kit in the mail that includes the *Mayo Clinic Guide to Healthy Pregnancy* book and a Maternity Care Diary.

28 Weeks: A Future Moms Program nurse will call to check in with You again at around week 28 of Your pregnancy. That nurse will discuss Your most recent checkup, confirm that You have had the appropriate tests and screenings and answer any questions You have about prenatal tests, delivery options, caring for Your baby or any other health concerns You may have.

After this phone call, You will receive another packet with helpful information about Your third trimester and preparing for labor, with topics including delivery options and postpartum depression.

After Delivery: Your Future Moms Program nurse will call You two to four weeks after Your delivery to check on how You and the baby are doing. Your nurse can also offer additional support if You have the "baby blues" or are suffering from postpartum depression. After this call, You will receive a birth kit that includes information on infant care and home safety.

Remember to contact Your Health Benefits Administrator within 30 days of the date of birth to add Your newborn to Your Empire Plan coverage. Refer to Your *General Information Book* for additional information.

Empire Plan Hospital Program

The following amendments apply to Plan documents for the Empire Plan Hospital Program.

Benefits Management Program

Hospital admission

Effective January 1, 2020, *Delete "*or an admission for the birth of a child*" from the first bullet and from the third paragraph of the third bullet.*

Add the following as the second sentence to **Maternity Admissions***:*

This includes maternity admissions for You when acting as a surrogate.

Network and Non-Network Benefits

*Delete "*mammography and*" from item A. in the* **Network Benefits** *bullet.*

Inpatient Hospital Care

Replace item K. in **Hospital Services Covered** *with the following:*

K. Dressings and casts.

Outpatient Hospital Care

Add the following as the second sentence to the bullet regarding **Surgery***:* See *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, page 57, for more information on Surgery.

Replace the bullet regarding **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** *with the following:*

- You are covered for mammograms, which may be provided by breast tomosynthesis (i.e., 3-D mammograms), for the screening of breast cancer as follows:

  A. One baseline mammogram for covered persons 35 through 39 years of age.

  B. Upon the recommendation of the covered person's Provider, an annual screening mammogram for covered persons 35 through 39 years of age if Medically Necessary.

  C. One screening mammogram annually for covered persons age 40 and over.

  If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) with a history of breast cancer, the Hospital Program covers mammograms as recommended by the treating Provider. However, in no event will more than one preventive screening per year be covered.

  Mammograms for the screening of breast cancer are not subject to copayment when provided by a participating provider.

  Additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and magnetic resonance imaging (MRIs) are covered. Screening and diagnostic imaging for the detection of breast cancer are not subject to copayment when provided by a participating provider.

Copayment for outpatient hospital services

*Delete "*including mammography, according to the above guidelines*" from the first bullet.*

Add the following new section after **Outpatient Hospital Care***:*

Telemedicine Benefit

LiveHealth Online

LiveHealth Online is a telemedicine benefit that helps You and Your covered dependents access health care services remotely. You can stay home and have a telephone or video visit with a board-certified doctor or licensed therapist on Your smartphone, tablet or personal computer.

When scheduling a visit with LiveHealth Online, it is important to enter Your name and Empire Plan ID number exactly as it appears on Your card, otherwise the claim may not be processed correctly.

To begin the registration process for remote care, go to www.empireblue.com/nys and select the link to LiveHealth Online. If You need assistance with the registration process or have questions, call LiveHealth Online at 1-888-LiveHealth (1-888-548-3432). LiveHealth Online has representatives available 24 hours a day, seven days a week. You may also call The Empire Plan and choose the Hospital Program for assistance with accessing LiveHealth Online.

Hospice Care

Delete the first sentence of the second paragraph under item A. **Hospice Organizations***:*

Coverage is subject to the network and non-network level of benefits if You have primary coverage through The Empire Plan.

Add the following new section after **Number of Days of Care***:*

Hospital Coverage outside of the United States

Hospital care under The Empire Plan is available worldwide. To maximize Your benefits and minimize Your out-of-pocket cost for care in a hospital outside of the United States, locate a BlueCross BlueShield Global Core participating facility in Your area. Visit www.bcbsglobalcore.com or call 1-800-810-BLUE (1-800-810-2583) to locate a participating facility. If calling from outside the continental United States, You can make a collect call to 1-804-673-1177.

If You know in advance that You will need care while out of the country, You should locate a BlueCross BlueShield Global Core participating facility in Your area prior to receiving care. If You receive inpatient care at a participating facility that was arranged through the BlueCross BlueShield Global Core Service Center, You may not be responsible for paying the full hospital costs at the time services are rendered and the provider will file the claim for You.

For all outpatient care, or if You have already paid the hospital, You must submit a claim and the Hospital Program will reimburse You directly for covered, medically necessary services (see *Filing and Payment of Hospital Claims*, page 35).

In the event of an emergency, You should go to the nearest hospital emergency department. However, if The Empire Plan determines that Your visit was not a medical emergency, Your expenses will not be covered under the Hospital Program. In this case, You can submit Your expenses to the Empire Plan Medical/Surgical Program to be considered for reimbursement.

Center of Excellence for Transplants Program

Replace the last sentence of the first paragraph with the following:

Effective January 1, 2020, Participation in the Center of Excellence for Transplants Program is voluntary, but the enhanced benefits under the Program are available only when You are enrolled in the Program and Your transplant services are preauthorized by the Hospital Program Administrator.

Delete the second paragraph:

If an enrollee has secondary coverage under The Empire Plan, and the enrollee's primary coverage/plan denies coverage at a facility described below that is covered under the Center of Excellence for Transplants Program, The Empire Plan will be considered the enrollee's primary coverage for purposes of this section. The enrollee or the enrollee's primary health plan must send the denial letter to the Empire Plan Hospital Program Administrator. For assistance with this process, contact The Empire Plan and choose the Hospital Program.

Preauthorization

Effective January 1, 2020, *Delete the last sentence:* To enroll in the Program and receive these benefits, The Empire Plan must be Your primary coverage.

Infertility Benefits

Replace the second and third paragraphs with the following:

Infertility benefits, including Qualified Procedures, are subject to the same copayments and deductibles as benefits for other medical conditions under the Hospital Program. Qualified Procedures are subject to a $50,000 lifetime maximum, however, **effective January 1, 2020**, up to three in-vitro fertilization (IVF) cycles will be covered and will not be subject to the $50,000 lifetime maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles is also not subject to the $50,000 lifetime maximum. For more information about travel, lodging and meal expenses associated with the Infertility Benefits Program, call the Medical/Surgical Program or see *Centers of Excellence Travel Allowance*, page 26.

Prior authorization is not required. However, it is recommended You call the Medical/Surgical Program Administrator to verify coverage of infertility benefits, or to find out how using a Center of Excellence offers You the highest level of benefits for infertility care.

Your coverage for this benefit will not be affected by Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity.

What is covered

Add the new section title ***Basic infertility services*** *after* **What is covered**.

*Add "*Administrator*" after "*Hospital Program*" in the last paragraph.*

Add the following new section after ***Basic infertility services****:*

Surrogacy and Donor Costs

Costs and services to a donor in facilitating surrogacy are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and limitations*, page 26, for more information.

However, Maternity services are covered for You when acting as a surrogate. For services covered, see *Inpatient Hospital Care* on page 16 and *Outpatient Hospital Care* on page 17.

Additional infertility benefits

Replace the section title, **YOU MUST CALL** *and the paragraph, first bullet and first sub-bullet after* **YOU MUST CALL** *with the following:*

Qualified Procedures

Additional infertility benefits called Qualified Procedures (specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility) may be available under the Medical/Surgical Program.

Qualified Procedures obtained in the inpatient or outpatient departments of a hospital are covered under the Hospital Program. The following Qualified Procedures are covered under The Empire Plan:

- Assisted reproductive technology (ART) procedures including:
  - In vitro fertilization (IVF) and embryo placement. An IVF cycle is all treatment that starts when:
    - Preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or
    - Medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer

Replace the second bullet with the following:

- Sperm, egg and/or inseminated egg, processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of eggs, sperm or embryos). When infertility could be the result of a medical treatment, see *Fertility preservation services* below.

Maximum lifetime benefit

Add the following to the end of the paragraph:

However, up to three IVF cycles will be covered and will not be subject to the $50,000 lifetime maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles is also not subject to the $50,000 lifetime maximum. For more information about travel, lodging and meal expenses associated with the Infertility Benefits Program, call the Medical/Surgical Program or see *Centers of Excellence Travel Allowance* below, page 26.

Add the following new section after **Maximum lifetime benefit***:*

Fertility preservation services

Fertility preservation is the process of saving or protecting eggs, sperm or embryos so that a person can use them to have biological children in the future. **Effective January 1, 2020**, Standard fertility preservation services are covered when a medical treatment will directly or indirectly lead to infertility. Examples of such medical treatments include surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Fertility preservation services are not subject to the Lifetime Maximum of $50,000 per covered individual. **Note:** Costs and services to a donor providing eggs or sperm to create embryos are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and Limitations*, page 26, for more information.

Infertility: Exclusions and limitations

Add the following as the first bullet:

- Qualified Procedures when You do not have a diagnosis of infertility.

Add the following to the end of the current second bullet:

See *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance* for coverage that is provided for these fertility drugs.

Replace the current fourth bullet with the following:

- Costs for and relating to surrogacy. However, maternity services are covered for You when acting as a surrogate. For services covered, see *Inpatient Hospital Care* on page 16 and *Outpatient Hospital Care* on page 17.

Delete the current third bullet:

- Medical expenses or other charges related to genetic selection.

Centers of Excellence Travel Allowance

*Delete "*preauthorized*" from the second paragraph.*

Hospital Program General Provisions

Exclusions and Limitations

What is not covered

Replace the last paragraph of item M. **Mental or Nervous Condition or Substance Use, Including Alcoholism** *with the following:*

Please refer to *Section IV: The Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, which contains all of the Mental Health and Substance Use benefits that are covered under The Empire Plan. You may also contact the Mental Health and Substance Use Program Administrator (see *Contact Information*, page 148) if You have any questions.

Delete item P. **Preventable Adverse Events and Conditions***:*

The Hospital Program will not pay for services related to events or errors in medical care that are clearly identifiable, preventable and serious in their consequences. You will not be responsible for these expenses:

- Preventable adverse events including foreign object retained after surgery, surgery performed on the wrong patient, wrong surgical procedure performed or surgery performed on the wrong body part.
- Preventable conditions including stage III and IV pressure ulcers, catheter-associated urinary tract infections, surgical site infections, manifestations of poor glycemic control, deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

If You Qualify for Medicare

Delete the last sentence under item B. **Active Employees and/or Their Dependents***:*

If You elect in writing to make Medicare Your primary coverage, Your coverage under this Plan will terminate.

Filing and Payment of Hospital Program Claims

Replace the first paragraph of the **Hospital Outside of the United States** *bullet under item B.* **If the Hospital Does Not Deal Directly with its Local BlueCross Plan** *with the following:*

Send an original itemized hospital bill in English or with a translation, if possible, a completed International Claim Form, located on the BlueCross BlueShield Global Core website, and Your Empire Plan identification number to the address listed in the *Contact Information* section, page 147.

Empire Plan Medical/Surgical Program

The following amendments apply to Plan documents for the Empire Plan Medical/Surgical Program.

Definitions

Replace the following:

J. Your **Copayment** is the first $25 that You are required to pay for certain services by Participating Providers, the first $30 in a participating Urgent Care Center or the first $50 in a participating outpatient surgical location.

AF. The **Lifetime Maximum** of the Basic Medical portion of this Plan and the Managed Physical Medicine Program is unlimited. The Lifetime Maximum for Qualified Procedures for infertility treatment is $50,000 (including any applicable travel, lodging and meal allowance) per covered person under the Empire Plan Hospital and Medical/Surgical Programs. However, **effective January 1, 2020**, up to three in vitro fertilization (IVF) cycles will be covered, not subject to the $50,000 Lifetime Maximum (including the covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for those cycles). After the three cycles are completed, additional Qualified Procedures (including covered travel, lodging and meal allowances when using a Center of Excellence for Infertility) are subject to the $50,000 Lifetime Maximum.

Replace the following re-lettered definitions:

AK. **Managed Physical Network (MPN) Network Allowance** means the payment for Covered Services agreed to by the Provider and OptumHealth Care Solutions, LLC (Optum) or Optum's affiliates.

AL. **Managed Physical Network (MPN) Non-Network Allowance** means the amount paid for a service that is determined by the Medical/Surgical Program Administrator and is applied according to established guidelines. The Non-Network Allowance is used by the Program Administrator as a basis for determining the amount of benefits You are entitled to receive under Non-Network coverage.

BE. **Telehealth** means a Provider's use of electronic information and communication technologies, including telephone or video using smart phones or other devices, to deliver Covered Services to You when You and Your Provider are in different locations.

BG. An **Urgent Care Center** is a licensed Facility other than a Hospital that provides Urgent Care. Urgent Care is typically available after normal business hours, including evenings and weekends.

Add the following definitions and alphabetize all definitions:

AG. **Managed Physical Medicine Program (MPMP) Network Allowance** means the amount Network Providers have agreed to accept as payment in full for services they render to You, including Your Copayments, under MPMP.

AH. **Managed Physical Medicine Program (MPMP) Network Providers** are those eligible Providers who have an agreement in effect to accept Your Copayment plus the MPMP Network Allowance as payment in full for chiropractic treatment, physical therapy and occupational therapy under MPMP.

AI. **Managed Physical Medicine Program (MPMP) Non-Network Allowance** means the lower of the following:

- The amount You actually paid for a Medically Necessary service covered under MPMP.
- 50 percent of the Managed Physical Network (MPN) Network Allowance for such service.

The MPN Non-Network Allowance for a service is determined by the Medical/Surgical Program Administrator and is applied according to established guidelines. The Non-Network Allowance is used by the Program Administrator as a basis for determining the amount of benefits You are entitled to receive under Non-Network coverage.

AJ. **Managed Physical Medicine Program (MPMP) Non-Network Provider** means a Provider who has not entered into an agreement to accept payment in accordance with the MPMP Network Allowance for chiropractic treatment, physical therapy and occupational therapy. You are responsible for paying a Non-Network Provider's charge. To receive reimbursement for such charges, You must file a claim with the Medical/Surgical Program. Payment will be sent directly to You. **The fees charged by a Non-Network Provider may exceed the amount reimbursed by the Medical/Surgical Program Administrator.**

Delete the definitions for **Managed Physical Network (MPN) Network Providers** *and* **Managed Physical Network (MPN) Non-Network Provider**.

Participating Provider Program

Your out-of-pocket expenses are lower when You choose Participating Providers

*Delete "***Urgent Care Center***" from the first sentence in the first paragraph.*

Add the following to the beginning of the second paragraph:

You pay only Your $30 Copayment for **Urgent Care Clinic** visits.

Combined out-of-pocket limit

In-network out-of-pocket limit

Replace this section with the following:

Effective January 1, 2022, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,650 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs.

Family Coverage

- $11,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs.

Finding Participating Providers

Replace the first and second paragraphs with the following:

UnitedHealthcare has a nationwide network of Providers. To learn whether a Provider participates in the UnitedHealthcare network for The Empire Plan:

- Always ask Your Provider if they are a Participating Provider and accepting new patients before You receive services.
- Call The Empire Plan and choose the Medical/Surgical Program or
- Check *The Empire Plan Participating Provider Directory* on NYSHIP Online (see *Contact Information*, page 146). From the NYSHIP Online homepage, select Find a Provider.

What is covered under the Participating Provider Program

Replace the following:

M. **Maternity Care** – You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, for complications of pregnancy and maternity services, including prenatal care, for You when acting as a surrogate. The Medical/Surgical Program Administrator's payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy, and a separate payment for the delivery and post-natal care provided. Perinatal depression screening for pregnant and postpartum patients is also covered.

Maternity care may be rendered by a Physician or other Provider such as a licensed or certified midwife. The midwife must be:

- Licensed or certified to practice midwifery and
- Permitted to perform the service under the laws of the state where the services are rendered.

There is no Copayment for prenatal visits, delivery and the six-week check-up after delivery. Prenatal ultrasounds/sonograms are not classified under the federal Patient Protection and Affordable Care Act (PPACA) or United States Preventive Services Task Force (USPSTF) as preventive services and may be subject to cost share.

Replace the following re-lettered definitions:

P. **Office and Home Visits** – You are covered for office visits and home visits by a Physician or other Provider for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-child care. General medical care includes routine and preventive pediatric care and routine and preventive adult care, including gynecologic exams.

If Your participating Physician or other Provider uses a Nonparticipating Provider for laboratory testing or interpretation of radiology, that service is covered under Basic Medical Program benefits, subject to Deductible and Coinsurance. However, if Your participating Physician refers laboratory testing to a Nonparticipating Provider without Your knowledge, You may be eligible for participating level benefits. See *Miscellaneous Provisions*, page 88, for more information about surprise bills or contact the Medical/Surgical Program for more information.

There is no Copayment for well-child office visits, including routine pediatric examinations, pediatric immunizations and the cost of oral and injectable substances, according to prevailing clinical guidelines.

There is no Copayment for professional services for allergy immunotherapy or allergy serum when billed by a Participating Provider. If there is an associated office visit, a Copayment will apply.

See *Preventive Care* on page 58.

Y. **Speech Therapy** – You are covered, subject to Copayment(s), for the services of a speech therapist or speech-language pathologist when all of the following apply:

- Such services are prescribed by a qualified Provider,
- Treatment is Medically Necessary and
- The Provider is currently licensed in the state where the service is rendered.

Add the following and alphabetize all definitions:

N. **Miscellaneous Services and Supplies** – When the Hospital Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Diagnostic laboratory procedures when the specimen is sent to the Hospital.
- Blood transfusions, including the cost of blood and blood products; however, such costs will be Covered Medical Expenses only to the extent that there is evidence, satisfactory to the Medical/Surgical Program, that such supplies could not be obtained without cost.
- Speech therapy.
- Occupational therapy.
- Physical therapy.
- Audiology exam and services.
- Cardiac rehabilitation.
- Pulmonary rehabilitation.
- Nutritional/diabetic counseling.

- Respiratory therapy.
- Durable medical equipment.
- Orthotics and prosthetics.
- Inpatient hospital facility charges (when Hospital Program benefits have been exhausted).
- Preventive services including radiology and laboratory services.

When the Prescription Drug Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Contraceptive drugs and devices that require injection, insertion or other Provider intervention when the drugs/devices are dispensed in a Provider's office.

Preventive Care

Replace the first sentence of the second paragraph with the following:

For more information on preventive care services, see *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 146). From the NYSHIP Online homepage, select Using Your Benefits. You can also go to www.hhs.gov/healthcare/rights/preventive-care.

Effective October 1, 2019*, Delete the age limit parenthetical "*(covered for enrollees and dependents age 19 through 26)*" for HPV immunizations in the second sentence of the* **Adult Immunizations** *bullet.*

Under the **Adult Immunizations** *bullet, delete "*Zostavax®*" from the second sentence and delete the fourth sentence:*

Zostavax is paid in full for enrollees and dependents age 60 or older and is subject to a Copayment for enrollees and dependents age 55 through 59.

Replace the second paragraph under the **Bone Mineral Density Measurements or Testing** *bullet with the following:*

The Program also covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Replace the bullet regarding **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** *with the following:*

- You are covered for mammograms, which may be provided by breast tomosynthesis (i.e., 3-D mammograms), for the screening of breast cancer, as follows:
  - One baseline screening mammogram for covered persons 35 through 39 years of age.
  - Upon the recommendation of the covered person's Provider, an annual screening mammogram for covered persons 35 through 39 years of age if Medically Necessary.
  - One screening mammogram annually for covered persons age 40 and over.

  If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) with a history of breast cancer, the Medical/Surgical Program covers mammograms as recommended by the treating Provider. However, in no event will more than one preventive screening per year be covered.

  Mammograms for screening of breast cancer are not subject to Copayment when provided by a Participating Provider.

  Additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and magnetic resonance imaging (MRIs), are covered. Screening and diagnostic imaging for the detection of breast cancer are not subject to Copayment when provided by a Participating Provider.

Under the **Well-Woman Examinations** *bullet, replace "*Pap smear*" with "*cervical cancer screening*" and replace the third sentence with the following:*

For a list of the covered preventive services, see *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 146). From the NYSHIP Online homepage, select Using Your Benefits. You can also go to www.hhs.gov/healthcare/rights/preventive-care.

Basic Medical Program

What is covered under the Basic Medical Program (Nonparticipating Providers)

Replace the following:

F. **Effective January 1, 2020, Emergency Services** – You are covered for Emergency Services that are performed to treat or stabilize Your emergency condition in a Hospital. Covered charges billed separately by the attending emergency department Physician and Providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and/or pathology services will be paid in full by the Medical/Surgical Program.

Services that are provided by other specialty Physicians or other Providers in a Hospital emergency department are paid in full.

If the emergency services, including inpatient services when admitted though the emergency department within New York State, are provided by other Nonparticipating Providers (e.g., surgeons), the charges will be paid in full.

The Empire Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from Nonparticipating Providers at a network facility without their knowledge. See *Miscellaneous/Provisions*, page 88, for more information about surprise bills or contact the Medical/Surgical Program for more information.

G. **Eye Care Following Cataract Surgery** – The charges for one pair of prescription eyeglasses or contact lenses and one eye examination are Covered Medical Expenses per affected eye per cataract surgery. These benefits are subject to Deductible and Coinsurance. Charges for tint, convenience or any add-on expenses will not be covered.

M. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer** – You are covered for mammograms, which may be provided by breast tomosynthesis (i.e., 3-D mammograms), subject to deductible and coinsurance for the screening of breast cancer, as follows:

- One baseline screening mammogram for covered persons age 35 through 39.
- Upon the recommendation of the covered person's Provider, an annual screening mammogram for covered persons 35 through 39 years of age if Medically Necessary.
- One screening mammogram annually for covered persons age 40 and older.

If a covered person of any age has a history of breast cancer or a first-degree relative (biological parent, sibling or child) has a history of breast cancer, the Medical/Surgical Program covers mammograms as recommended by the treating Provider. However, in no event will more than one preventive screening per year be covered.

If You are eligible for the Routine Health Exam benefit, mammograms are not subject to Deductible or Coinsurance. See item AA. *Routine Health Exams for Active Employees*, page 66.

Additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and magnetic resonance imaging (MRIs), are covered. Screening and diagnostic imaging for the detection of breast cancer are subject to Deductible and Coinsurance when provided by a Nonparticipating Provider.

P. **Maternity Care** – You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth, for complications of pregnancy and maternity services, including prenatal care, for You when acting as a surrogate. The Medical/Surgical Program Administrator's payment of maternity benefits may be made in up to two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy and a separate payment for the delivery and post-natal care provided. Perinatal depression screening for pregnant and postpartum patients is also covered.

Maternity care may be rendered by a Physician or other Provider such as a licensed or certified midwife. The midwife must be:

- Licensed or certified to practice midwifery and
- Permitted to perform the service under the laws of the state where the services are rendered.

Q. **Miscellaneous Services and Supplies** – When the Hospital Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Diagnostic laboratory procedures when the specimen is sent to the Hospital.
- Blood transfusions, including the cost of blood and blood products; however, such costs will be Covered Medical Expenses only to the extent that there is evidence, satisfactory to the Medical/Surgical Program, that such supplies could not be obtained without cost.
- Speech therapy.
- Occupational therapy.
- Physical therapy.
- Audiology exam and services.
- Cardiac rehabilitation.
- Pulmonary rehabilitation.
- Nutritional/diabetic counseling.
- Respiratory therapy.
- Durable medical equipment.
- Orthotics and prosthetics.
- Inpatient hospital facility charges (when Hospital Program benefits have been exhausted).
- Laboratory services (including pathology).

When the Prescription Drug Program Administrator does not cover the following items, the Medical/Surgical Program will cover them when Medically Necessary:

- Contraceptive drugs and devices that require injection, insertion or other Provider intervention when the drugs/devices are dispensed in a Provider's office.

R. **Modified Solid Food Products** – When prescribed by a Physician or other Provider, modified solid food products (MSFPs) are covered. This benefit is not subject to Deductible or Coinsurance.

Modified solid food products include products that are low in protein or that contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.

Add the following and alphabetize the list:

AF. **Speech Therapy** – You are covered for Speech Therapy under the same conditions as the Participating Provider Program, subject to Deductible and Coinsurance.

Out-of-Network Referral

Replace the second paragraph with the following:

This requirement applies to Empire Plan-primary enrollees residing in the United States and United States territories. If You require access to a certain Provider, contact the appropriate Empire Plan Program Administrator (see *Contact Information*, page 146).

Managed Physical Medicine Program

Replace the first sentence with the following:

The Managed Physical Medicine Program (MPMP) is administered by Optum™ Physical Health, which includes Managed Physical Network, Inc. (MPN) and OptumHealth Care Solutions, LLC.

Network benefits

Replace this section with the following:

You pay a $25 Copayment for each office visit for chiropractic treatment, physical therapy or occupational therapy when You choose a Network Provider. You pay an additional $25 Copayment for related radiology and diagnostic laboratory services billed by the Network Provider. If a Network Provider bills for radiology and diagnostic laboratory services performed during a single office visit, only one Copayment for both radiology and diagnostic services will apply.

$25 Copayments when You use a Network Provider

*Replace the first reference to "*MPN*" with "*MPMP*" and delete the second reference to "*MPN.*"*

How to find a Network Provider

*Delete "*MPN*" throughout this section.*

Guaranteed access

*Delete the first reference to "*MPN*" and replace the third reference to "*MPN*" with "*MPMP.*"*

Replace the second-to-last sentence with the following:

MPMP will make arrangements for You to receive Medically Necessary chiropractic treatment, physical therapy or occupational therapy, and You will pay only Your $25 Copayment for each visit.

Non-network benefits

*Replace "*MPN*" with "*MPMP.*"*

Infertility Benefits

Replace the second and third paragraphs with the following:

Infertility benefits, including Qualified Procedures, are subject to the same Copayments, Deductibles, Coinsurance maximums and percentages payable as benefits for other medical conditions under the Participating Provider and Basic Medical Programs. Qualified Procedures are subject to a $50,000 Lifetime Maximum; however, **effective January 1, 2020**, up to three in vitro fertilization (IVF) cycles will be covered and will not be subject to the $50,000 Lifetime Maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles are also not subject to the $50,000 Lifetime Maximum.

Prior Authorization is not required. However, it is recommended You call the Medical/Surgical Program Administrator to verify coverage of infertility benefits or to find out how using a Center of Excellence offers You the highest level of benefits for infertility care.

By using Participating Providers, You minimize Your out-of-pocket costs.

Your coverage for this benefit will not be affected by Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity.

What is covered

Add the new section title ***Basic infertility services*** *after* **What is covered**.

Replace the first paragraph with the following:

Covered Services and supplies include, but are not limited to:

- Patient education/program orientation
- Diagnostic testing
- Ovulation induction/hormonal therapy
- Artificial/intrauterine insemination
- Surgery to enhance reproductive capability

Add the following new section after ***Basic infertility services****:*

Surrogacy and Donor Costs

Costs and services to a donor in facilitating surrogacy are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and limitations*, page 76, for more information.

However, maternity services, including prenatal care, are covered for You when acting as a surrogate. See *Maternity Care*, page 56, for Participating Provider coverage or page 65 for Basic Medical coverage.

Replace **YOU MUST CALL** *and the paragraph, first bullet and first sub-bullet after* **YOU MUST CALL** *with the following:*

Qualified Procedures

Qualified Procedures are specialized procedures that facilitate a pregnancy, but do not treat the cause of the infertility. The following Qualified Procedures are covered under The Empire Plan:

- Assisted reproductive technology (ART) procedures, including:
  - In vitro fertilization (IVF) and embryo placement. An IVF cycle is all treatment that starts when:
    - Preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or
    - Medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer

Replace the second bullet with the following:

- Sperm, egg and/or inseminated egg, processing and banking of sperm or inseminated eggs. This includes expenses associated with cryopreservation (freezing and storage of eggs, sperm or embryos). When infertility could be the result of a medical treatment, see *Fertility preservation services* below.

Maximum lifetime benefit

Add the following to the end of the paragraph:

However, up to three IVF cycles will be covered and will not be subject to the $50,000 Lifetime Maximum. Covered travel, lodging and meal benefits when using a Center of Excellence for Infertility for these three IVF cycles is also not subject to the $50,000 Lifetime Maximum.

Add the following new section after **Maximum lifetime benefit***:*

Fertility preservation services

Fertility preservation is the process of saving or protecting eggs, sperm or embryos so that a person can use them to have biological children in the future. **Effective January 1, 2020**, Standard fertility preservation services are covered when a medical treatment will directly or indirectly lead to infertility. Examples of such medical treatments include surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Fertility preservation services are not subject to the Lifetime Maximum of $50,000 per covered individual. **Note:** Costs and services to a donor providing eggs or sperm to create embryos are not covered. This includes any charges for services provided to a donor and any donor compensation. See *Infertility: Exclusions and Limitations*, page 26, for more information.

Center of Excellence for Infertility

Replace the second and third sentences with the following:

These centers are available to provide to You the listed Covered Services and supplies, Qualified Procedures and fertility preservation services. Benefits for infertility treatment and fertility preservation services at a Center of Excellence for Infertility are payable in full.

Infertility: Exclusions and Limitations

Add the following as the first bullet:

• Qualified Procedures when You do not have a diagnosis of infertility.

Add the following to the end of the current second bullet:

See *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance* for coverage that is provided for these fertility drugs.

Replace the current third bullet with the following:

• Costs for and relating to surrogacy. However, maternity services, including prenatal care, are covered for You when acting as a surrogate. See *Maternity Care*, page 56, for Participating Provider coverage or page 65 for Basic Medical coverage.

Center of Excellence for Cancer Program

Enrollment

Add the following to the end of the paragraph:

You are encouraged to call and renew Your case annually.

Centers of Excellence Travel Allowance

Replace the first sentence of the first paragraph with the following:

When You enroll in the Center of Excellence for Cancer Program or receive covered infertility services from a Center of Excellence, You will not have to make any Copayments for services performed at a qualified Center of Excellence.

*Delete "*preauthorized*" from the second paragraph.*

Medical/Surgical Program General Provisions

Exclusions and limitations

Replace item O. **Mental Health and Substance Use** *with the following:*

O. **Mental Health and Substance Use.** Expenses for mental health or substance use services, supplies and Pharmaceutical Products, including alcoholism. Refer to *Section IV: The Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, which contains all of the Mental Health and Substance Use benefits that are covered under The Empire Plan. You may also contact the Mental Health and Substance Use Program Administrator (see *Contact Information*, page 148) if You have any questions.

Impact of Medicare on this Plan

How The Empire Plan calculates benefits when Medicare is Primary

*Replace "*Managed Physical Network (MPN)*" with "*Managed Physical Medicine Program (MPMP)*" in the first paragraph.*

*Replace "*MPN*" with "*MPMP*" in the third bullet.*

How, When and Where to Submit Claims

How

*Delete "*Managed Physical Network (MPN) Network Provider*" in item A.*

*Delete "*is not in the MPN network or*" in the first paragraph of item B.*

When

*Delete "*MPN Network Provider*" in item A.*

*Delete "*is not in the MPN network or*" in the first paragraph of item B.*

Appeals

Level 2 Appeals

Add the following to the end of the first paragraph: **Note:** The four-month time frame for filing an External Appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second-level Appeal, the time may expire for You to file an External Appeal.

Empire Plan Mental Health and Substance Use Program

The following amendments apply to Plan documents for the Empire Plan Mental Health and Substance Use Program.

*Change all instances of "*Mental Health and Substance Abuse (MHSA) Program*" to "*Mental Health and Substance Use (MHSU) Program.*"*

Coverage

*Replace the sentence after "***Important:** See your *General Information Book* along with this *Certificate* for other conditions that may affect this coverage.*" with:*

If You have questions about benefits available under the Program, You or a member of Your family or household may call the Program Administrator (see *Contact Information*, page 148).

Meaning of Terms Used

Replace the following defined terms:

B. **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Addiction Services and Supports of the State of New York or according to the Mental Hygiene Law of New York State. If located outside of New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug use treatment or accredited by the appropriate State agency for the level of care received. Partial hospitalization, intensive outpatient program, day treatment, 23-hour extended bed and 72-hour crisis bed will be considered Approved Facilities if they satisfy the foregoing requirements. Under Network Coverage, residential treatment centers, halfway houses and group homes will be considered Approved Facilities if they satisfy the requirements listed previously and admission is Certified by the Program Administrator. See the definitions for Network Facility and Non-Network Facility for more information. In all cases other than an emergency, the facility must also be approved by the MHSU Program Administrator. **Note:** Services received at an Approved Facility, except emergency services, are subject to a Medical Necessity determination.

M. **Covered Expenses** means:

- Under Network Coverage, the Network Allowance for any Medically Necessary Covered Services provided to You by a Network Provider.
- Under Non-Network Coverage, the Usual and Customary charge by a Non-Network Practitioner. These services must be Medically Necessary as defined in item S. on page 102. No more than the Usual and Customary charge will be considered by the Program for Medically Necessary Covered Services. More detail on Covered Expenses is provided in the section *Schedule of Benefits for Covered Services*, page 110.

Covered Expenses are incurred on the date the service is received by You.

Charges for services performed by a person or facility not listed in the definition of Practitioner or Approved Facility are **not** Covered Expenses under the Program. A more detailed description of exclusions is provided on page 112.

AH. **Effective August 1, 2019**, **Practitioner** means:

- A psychiatrist.
- A psychologist.

- A licensed mental health counselor (a counselor trained in counseling, psychotherapy and prevention). Counselors work with individuals, couples, families, groups and organizations using brief techniques, such as crisis intervention and solution-focused approaches, or longer-term approaches when treating chronic mental health disorders or disabilities.
- A licensed marriage and family therapist (a therapist trained in individual psychotherapy and family systems to assess and treat mental, emotional and behavioral disorders and address an array of relationship issues within the context of marital/couple, family, relational and group therapy). Therapists provide individual, couple, family, relational and group therapy.
- A licensed clinical social worker in New York State who qualifies for the "R" privilege. If services are performed outside of New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body.
- A Physician Assistant (PA) is licensed and qualified by academic and practical training to provide patient services under the supervision and direction of a licensed Physician who is responsible for the performance of the PA.
- A registered nurse clinical specialist or psychiatric nurse/clinical specialist (an advanced practice nurse who holds a master's or doctoral degree in a specialized area of psychiatric nursing practice).
- A registered nurse practitioner (a nurse with a Master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided and who must be certified and have a practice agreement in effect with a network psychiatrist). Nurse practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols.
- Applied Behavior Analysis (ABA) Provider (a licensed Provider certified as a behavior analyst pursuant to a behavior analyst certification board).
- ABA agency (an agency providing ABA services under the Program oversight and direct supervision of a licensed Provider and certified behavior analyst). An ABA agency may also employ ABA aides to deliver the treatment protocol of the ABA Provider. Coverage of behavioral health services by an ABA agency or ABA aide does not extend to basic behavioral health coverage or to non-ABA services.

AO. **Structured Outpatient Rehabilitation Program** means a program that provides Substance Use Care and is an operational component of an Approved Facility that is state licensed. If located in New York State, the program must be certified by the Office of Addiction Services and Supports of the State of New York.

The program must also meet all applicable federal, state and local laws and regulations.

A Structured Outpatient Rehabilitation Program is a program in which the patient participates, on an outpatient basis, in prescribed formalized treatment, including an aftercare component of weekly follow up. In addition, Structured Outpatient Rehabilitation programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

What is Covered Under the MHSU Program

Outpatient Services

Effective January 1, 2021, *Replace the last sentence of item I.* **Electroconvulsive Therapy (ECT)** *with the following:*

On and after January 1, 2021, ECT is no longer required to be Certified by the Program Administrator **before** the service is received.

Schedule of Benefits for Covered Services

Delete the seventh bullet:

• Electroconvulsive Therapy (ECT) – inpatient and outpatient

Add an asterisk to the current eleventh and twelfth bullets as follows:

• Residential treatment center for mental health*

• Residential treatment center for substance use disorder**

Replace the footnote with the following:

* **Effective January 1, 2020**, Precertification is not required for covered individuals under 18 years of age at Office of Mental Health–certified network facilities located within New York State.

** Precertification is not required for Office of Addiction Services and Supports–certified network facilities located within New York State.

Mental health inpatient services for children younger than 18 at an Office of Mental Health facility does not require precertification.

Maximums

Replace the first paragraph with the following:

Mental Health Care and Substance Use Care coverage is unlimited (no maximum) for Medically Necessary Outpatient and Inpatient Services, except that outpatient treatment sessions for family members of a substance user are covered for a maximum of 20 visits per year for all family members combined.

Exclusions and Limitations

Replace item D. with the following:

D. Services where there is no underlying behavioral health condition and that are solely for the purpose of professional or personal growth, marriage counseling, development training, professional Certification, obtaining or maintaining employment or insurance or solely pursuant to judicial or administrative proceedings.

*Delete "*alcoholism*" from item E.*

Miscellaneous Provisions

Confined on effective date of coverage

*Delete both instances of "*treatment*" after "*Substance Use Care.*"*

Confined on date of change of options

*Delete "*treatment*" after "*Substance Use Care*" in the second paragraph.*

Empire Plan Prescription Drug Program

The following amendments apply to Plan documents for the Empire Plan Prescription Drug Program.

Meaning of Terms Used

Replace the following defined terms:

A. **Ancillary Charge** means the amount in addition to the applicable copayment an enrollee will pay when purchasing a Brand-Name Drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the discounted ingredient cost of the dispensed Brand-Name Drug and the discounted ingredient cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug.

The Ancillary Charge does not apply if a Dispense as Written Exception Request is approved by the Plan; however, the enrollee must pay the applicable non-preferred brand copayment.

I. **Excluded Drug** is a drug that is excluded from coverage under this Program's benefit plan and/or 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. See the definition for *Medical Exception Program* for information on how to Appeal an Excluded Drug.

J. **Formulary.** In a Formulary, including an Advanced Flexible or 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.

Add the following defined term and re-letter the list:

D. **Dispense as Written (DAW) Exception Request** is a process by which a physician submits a request to the Program showing that it is medically necessary for You to have a non-preferred Brand-Name Drug (that has a generic equivalent). If approved, You would pay the non-preferred Copayment, but You will not have to pay the Ancillary Charge.

Your Benefits and Responsibilities

Copayments

Add the following to the end of the **Note***:*

Information on preventive medications that are available without cost sharing is available in *The Empire Plan Preventive Care Coverage Guide* on NYSHIP Online (see *Contact Information*, page 146).

Supply and coverage limits

Replace the second paragraph with the following:

Effective April 1, 2021, Erectile dysfunction drugs, which can also be used for benign prostatic hyperplasia, are limited to 30 units for a 30-day supply and 90 units for a 90-day supply. All other erectile dysfunction drugs are limited to six units every 30 days and 18 units every 90 days.

Replace the last paragraph with the following:

Effective January 1, 2020, You may have a 12-month supply of a contraceptive drug or device dispensed to You.

Mandatory generic substitution

Replace the last four paragraphs with the following new section:

Dispense as Written Exception Requests

If Your Doctor believes it is medically necessary for You to have a non-preferred Brand-Name Drug (that has a generic equivalent), You may submit a DAW Exception Request. To begin the DAW Exception Request process, Your Doctor should submit a DAW Exception Request or call The Empire Plan and choose the Prescription Drug Program. See *Contact Information*, page 151, for details.

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 the non-preferred copayment. You will not have to pay the Ancillary Charge. If Your DAW Exception Request is denied, You may Appeal to the Program Administrator.

Act promptly. 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.

Prior authorization required for certain drugs

Replace the second and third paragraphs with the following:

Certain drugs that require prior authorization based on age, gender or quantity-limit specifications are not listed. Compound Drugs that have a claim cost to the Program that exceeds $200 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 and to learn how to obtain prior authorization, call The Empire Plan and choose the Empire Plan Prescription Drug Program or go to NYSHIP Online (see *Contact Information*, page 146). From the NYSHIP Online homepage, select Using Your Benefits and then Prior Authorization Drug List.

What is covered

Delete the last sentence from the footnote:

Zostavax® is paid in full for enrollees and dependents age 60 or older and is subject to a Level 1, 30-day supply Copayment for enrollees and dependents age 55 through 59.

Add the following items:

P. 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). **Note:** When available over-the-counter, USPSTF “A” and “B” rated medications require a prescription order to process without cost sharing.

Q. Pre-Exposure Prophylaxis (PrEP), when prescribed for enrollees who are at high risk of acquiring HIV.

Exclusions and Limitations

Replace the following items:

G. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments or other non-medicinal substances), with the exception of certain diabetic supplies, regardless of their intended use.

P. Prescription drug products excluded from the benefit plan design.

Replace the **Important** *note with the following:*

Refer to *Home Care Advocacy Program (HCAP)* in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, page 68, for coverage for Prescription drugs billed by a home care agency.

Note: For a current list of Excluded Drugs, go to NYSHIP Online (see *Contact Information*, page 146). From the NYSHIP Online homepage, select Using Your Benefits and then click on the Excluded Drug List.

How to Use Your Empire Plan Prescription Drug Program

Mail Service Pharmacy or the Designated Specialty Pharmacy

Replace the first sentence of the second paragraph with the following:

You must request that Your Doctor send Your prescription to the Mail Service Pharmacy and then You will receive up to a 90-day supply of Your Prescriptions, shipped by first-class mail or private carrier.

Coverage for preventive vaccines administered in a Vaccination Network Pharmacy

Delete the fourth bullet:

- The no-copayment benefit for Zostavax® applies to enrollees and dependents age 60 or older (per PPACA recommendations). Zostavax® is subject to a Level 1, 30-day supply Copayment for enrollees and dependents age 55 through 59.

Miscellaneous Provisions

Medical Exception Program for drugs excluded from the Advanced Flexible Formulary (for Empire Plan-primary enrollees)

Replace the last two sentences of the first paragraph with the following:

The physician may fax the Medical Exception Request (see *Contact Information*, page 149, for details). If the Medical Exception is approved, the Level 1 copayment will apply for Generic Drugs and the Level 3 copayment will apply for Brand-Name Drugs.

Contact Information

The Empire Plan

PRESS OR SAY 2 Hospital Program

Administered by Empire BlueCross

Written appeals

Replace this section with the following:

Empire BlueCross
Empire Plan Appeals Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

PRESS OR SAY 3 Mental Health and Substance Use Program

Administered by Beacon Health Options

Add the following before ***Written appeals****:*

Claims submission forms can be submitted via the MemberConnect portal:
www.beaconhealthoptions.com/members/beacon/

PRESS OR SAY 4 Prescription Drug Program

Administered by CVS Caremark

Claims

Replace this section with the following:

Mail:
The Empire Plan Prescription Drug Program
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Online:
Log on to Caremark.com and choose Submit a Claim under Plan & Benefits.

Add the following before ***Written appeals****:*

Dispense as Written Exception Requests for non-preferred Brand-Name Drugs on the Advanced Flexible Formulary

Request forms are available on NYSHIP Online or at www.caremark.com/portal/asset/NYSHIP_DAW_Exception_Request_Form.pdf.

Tell Your physician to fax these Requests to 1-888-487-9257.