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 the **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, 2022

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, 2022.***

Empire Plan Certificate of Insurance

Combined Out-of-Pocket

In-Network Out-of-Pocket Limit

Replace this section with the following:

Effective January 1, 2023, the annual out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,900 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $3,200 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Family Coverage

- $11,800 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
  - The $5,900 Individual Coverage limit applies for each Plan enrollee with Family Coverage; the maximum amount of $11,800 applies for all enrollees combined
- $6,400 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)
  - The $3,200 Individual Coverage limit applies for each Plan enrollee with Family Coverage; the maximum amount of $6,400 applies for all enrollees combined

Empire Plan Benefits Management Program

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

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

E. Medical case management

Replace the first sentence with the following:

Medical case management is a voluntary program to help You identify and coordinate covered services under The Empire Plan Benefits Management Program when Your primary coverage is The Empire Plan.

Voluntary specialist consultant evaluation

Replace the first sentence with the following:

When Your primary coverage is The Empire Plan, You may request a voluntary specialist consultant evaluation for any scheduled procedure.

Empire Plan Hospital Program

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

Add the following new section before **Inpatient Hospital Care:**

Transitional Care

Continuity of care: When a Hospital or Facility leaves the network

If You are in an ongoing course of treatment when a Hospital or Facility leaves the network, then You may continue to receive Covered Services for the ongoing treatment from the former Network Hospital or Facility for up to 90 days from the date the Hospital's or Facility's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with the former Network Hospital or Facility through delivery and any postpartum care directly related to the delivery.

The Hospital or Facility must provide necessary medical information related to Your care and adhere to the Program Administrator's policies and procedures, including those for assuring quality of care, and for obtaining preauthorization and a treatment plan approved by the Hospital Program Administrator. You will receive the Covered Services as if they were being rendered by a Network Hospital or Facility. You will be responsible only for any applicable in-network cost-sharing. Under applicable law, the Hospital or Facility must accept as payment the negotiated allowance that was in effect just prior to the termination of the Program Administrator's relationship with the Hospital or Facility. Please note that if the Hospital or Facility was terminated by the Hospital Program Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Hospital's or Facility's ability to provide medical care, continued treatment will not be available.

Transition of care: New enrollees in a course of treatment

If You are in an ongoing course of treatment with a Non-Network Hospital or Facility when Your coverage under this *Certificate* becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Network Hospital or Facility for up to 60 days from the effective date of Your coverage under this *Certificate*. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Network Hospital or Facility if You are in the second or third trimester of a pregnancy when Your coverage under this *Certificate* becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

To continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Network Hospital or Facility must accept as payment the Hospital Program Administrator's negotiated allowances for such services. The Hospital or Facility must provide necessary medical information related to Your care and to adhere to the Program Administrator's policies and procedures, including those for assuring quality of care and for obtaining preauthorization and a treatment plan approved by the Hospital Program Administrator. You will receive the Covered Services as if they were being rendered by a Network Hospital or Facility. You will be responsible only for any applicable in-network cost-sharing.

Inpatient Hospital Care

Replace item P. under **Hospital Services Covered** *with the following:*

Air ambulance service (fixed wing and rotary wing). Coverage for air ambulance related to an emergency condition or air ambulance related to nonemergency transportation is provided to the nearest Hospital where Emergency Care can be performed when Your medical condition is such that transportation by land ambulance is not appropriate; Your medical condition requires immediate and rapid ambulance transportation and transportation cannot be provided by land ambulance; and one of the following is met:

- The point of pick-up is inaccessible by land vehicle

- Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities

For information regarding ground ambulance providers, see *Section III: The Empire Plan Medical/ Surgical Program Certificate of Insurance*, page 67.

Telemedicine Benefit

LiveHealth Online

Replace this section with the following:

LiveHealth Online is a telemedicine benefit that helps You and Your covered dependents access health care services remotely. You can have a telephone or video visit with a board-certified doctor, psychiatrist, psychologist or licensed therapist on Your smartphone, tablet or personal computer at no cost to You.

When scheduling a visit with LiveHealth Online, it is important to enter Your name and Empire Plan identification 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. When registering, select Empire BlueCross as Your health insurance carrier to ensure Your copayment is waived. 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 (see *Contact Information*, page 151) for assistance with accessing LiveHealth Online.

Hospice Care

Replace item C. **Hospice Care Covered** *with the following:*

Hospice care is covered during the period when the hospice has accepted You for its hospice program. **Effective July 1, 2019**, you are eligible for hospice care if Your doctor and the hospice medical director certify that You are terminally ill and likely have less than 12 months to live. You may access hospice care while participating in a clinical trial or continuing disease-modifying therapy (therapy that treats the underlying terminal illness), as ordered by Your treating physician. The following services provided by the hospice organization are covered:

- Bed patient care either in a designated hospice unit or in a regular hospital bed.
- Day care services provided by the hospice organization.
- Home care and outpatient services that are provided by the hospice and for which the hospice charges You. The services may include at least the following:
  - Intermittent nursing care by an R.N., L.P.N. or home health aide.
  - Physical therapy.
  - Speech therapy.
  - Occupational therapy.
  - Respiratory therapy.
  - Social services.
  - Nutritional services.
  - Laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms.
  - Medical supplies.

- Drugs and medications prescribed by a physician that are considered approved under the U.S. Pharmacopoeia and/or National Formulary. The Hospital Program will not pay when the drug or medication is of an experimental nature, except as otherwise required by law.
- Medical care provided by the hospice physician.
- Respite care.
- Bereavement services provided to Your family during illness and until one year after death.

Empire Plan Medical/Surgical Program

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

Throughout the Empire Plan Medical/Surgical Program Certificate of Insurance*, replace all instances of "*Pharmaceutical Products*" and "*Pharmaceutical Product*" with "*Pharmaceutical Products or Devices*" and "*Pharmaceutical Product or Device*," respectively.*

Definitions

Replace item AQ. with the following:

Pharmaceutical Product or Device means an FDA-approved prescription Pharmaceutical Product or Device including a biologic product or device ordered and administered to You by a Physician or other Provider within the scope of the provider's license.

Add the following and re-letter the remaining items:

E. **Biologic Product or Device** means a Pharmaceutical Product or Device developed from human cell proteins and DNA targeted to treat disease at the cellular level.

Participating Provider Program

Combined out-of-pocket limit

In-network out-of-pocket limit

Replace this section with the following:

Effective January 1, 2023, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,900 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs

Family Coverage

- $11,800 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs
  - The $5,900 Individual Coverage limit applies for each Plan enrollee with Family Coverage; the maximum amount of $11,800 applies for all enrollees combined

What is covered under the Participating Provider Program

Replace the following:

H. **Gender Affirmation Treatment** – Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery is covered when Your behavioral health provider, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a written psychological assessment documenting that You have a diagnosis of gender dysphoria, the capacity to make a fully informed decision and to consent for treatment and are at least 18 years of age. **Effective May 13, 2021**, consideration of gender affirming chest procedures in individuals under 18 years of age may be requested.

Any other associated surgeries, services and procedures, including those done 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, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a determination of Medical Necessity and confirms that You have a diagnosis of gender dysphoria, have the capacity to make

a fully-informed decision and consent for treatment and are 18 years of age or older. While not required, a Predetermination review, also known as a preservice claim determination, is available (see *Preservice claim determinations*, page 90, for more information).

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:

- Audiology exam and services.
- 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.
- Cardiac rehabilitation.
- Diagnostic laboratory procedures when the specimen is sent to the Hospital.
- Durable medical equipment.
- Emergency Services when rendered at a freestanding emergency department (Copayment for Emergency Care applies. See *Section II: The Empire Plan Hospital Program and Related Expenses Certificate of Insurance*, page 20, for more information).
- Inpatient hospital facility charges (when Hospital Program benefits have been exhausted).
- Nutritional/diabetic counseling.
- Occupational therapy.
- Orthotics and prosthetics.
- Pharmaceutical Products or Devices administered by Your Health Care Professional.
- Physical therapy.
- Preventive services including radiology and laboratory services.
- Pulmonary rehabilitation.
- Respiratory therapy.
- Speech therapy.

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.
- Pharmaceutical Products or Devices administered by Your Health Care Professional.

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, well-child care and Pharmaceutical Products or Devices administered by Your Provider. 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 92, for more information about surprise bills or call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 151) 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 60.

Add the following and re-letter the list:

W. **Reproductive Access to Health Care Services** – You are covered when a Physician or other Health Care Professional provides therapeutic or elective pregnancy interruption (abortion) services, including post-operative care, when not covered elsewhere by the Plan. There is no Copayment for these services. Emergency contraception dispensed during a provider's office visit is also covered. There is no Copayment for these reproductive health care services. Emergency contraception and pregnancy interruption medications that are dispensed to You by a licensed pharmacy are subject to the provisions of Your Prescription Drug Program (see *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*, page 136). For other family planning services available to You, see *Family Planning and Reproductive Health Services*, page 61.

Preventive Care

Add the following bullet after the **Bone Mineral Density Measurements or Testing** *bullet:*

- **Breastfeeding Support, Supplies and Counseling** – Includes cost for purchase of a double-electric breast pump following the birth of Your child. This is a network benefit only; You must utilize a Medical/Surgical Program national Provider.

Replace the last sentence of the first paragraph of the **Family Planning and Reproductive Health Services** *bullet with the following:*

Over-the counter (OTC) family planning supplies, such as condoms and spermicides, are not covered under the Medical/Surgical Program. See *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*, page 136, for more information regarding coverage of OTC family planning supplies.

Transitional Care

Continuity of care: When Your Provider leaves the network

Replace this section with the following:

If You are in an ongoing course of treatment when Your Provider leaves the Participating Provider network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must provide necessary medical information related to Your care and adhere to the Program Administrator's policies and procedures, including those for assuring quality of care, and for obtaining preauthorization and a treatment plan approved by the Medical/Surgical Program Administrator. You will receive the Covered Services as if they were being rendered by a Participating Provider. You will be responsible only for any applicable in-network cost-sharing. Under applicable law, the Provider must accept as payment the negotiated allowance that was in effect just prior to the termination of the Program Administrator's relationship with the Provider. Please note that if the Provider was terminated by the Medical/Surgical Program Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

Transition of care: New course of treatment

Rename this section **Transition of care: New enrollees in a course of treatment**.

Replace the second paragraph with the following:

To continue to receive Covered Services for up to 60 days or through pregnancy, the Nonparticipating Provider must accept as payment the Medical/Surgical Program Administrator's negotiated allowances for such services. The Provider must provide necessary medical information related to Your care and to adhere to the Program Administrator's policies and procedures, including those for assuring quality of care and for obtaining preauthorization and a treatment plan approved by the Medical/Surgical Program Administrator. You will receive the Covered Services as if they were being rendered by a Participating Provider. You will be responsible only for any applicable in-network cost-sharing.

Basic Medical Program

Assignment of benefits to a Nonparticipating Provider is not permitted

Replace the second sentence with the following:

Assignments will be made to Hospitals and for ground ambulance services as long as the ambulance service has a contract in effect with the Medical/Surgical Program and to Providers in the Empire Plan Basic Medical Provider Discount Program.

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

*Rename "*Ambulance Service*" as "*Ground Ambulance Service,*" and replace the re-lettered item with the following:*

H. **Ground Ambulance Service** – Emergency ground ambulance transportation to the nearest Hospital where Emergency Care can be performed is covered when the service is provided by a licensed ambulance service and ambulance transportation is required because of an emergency condition. Medically Necessary nonemergency transportation is covered if provided by a licensed ambulance service.

   Covered Medical Expenses for ambulance services include the following:

   - Local commercial ambulance charges except for the first $70. These amounts are not subject to Deductible or Coinsurance.
   - When the enrollee has no obligation to pay, donations up to a maximum of $50 for trips of fewer than 50 miles and up to $75 for trips over 50 miles will be reimbursed for voluntary ambulance services. These amounts are not subject to Deductible or Coinsurance.

   For air ambulance service (fixed wing and rotary wing), see *Section II: The Empire Plan Hospital Program and Related Expenses Certificate of Insurance*, page 17.

Add the following and re-letter the list:

AA. **Reproductive Access to Health Care Services** – You are covered when a Physician or other Health Care Professional provides therapeutic or elective pregnancy interruption (abortion) services, including post-operative care, when not covered elsewhere by the Plan. These services are subject to Deductible and Coinsurance.

   Emergency contraception dispensed during a provider's office visit is also covered, subject to Deductible and Coinsurance. Emergency contraception and pregnancy interruption medications that are dispensed to You by a licensed pharmacy are subject to the provisions of Your Prescription Drug Program (see *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*, page 136).

   For other family planning services available to You, see *Family Planning and Reproductive Health Services*, page 61.

Replace the following:

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:

- Audiology exam and services.
- 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.
- Cardiac rehabilitation.
- Diagnostic laboratory procedures when the specimen is sent to the Hospital.
- Durable medical equipment.
- Emergency Services when rendered at a freestanding emergency department (Copayment for Emergency Care applies. See *Section II: The Empire Plan Hospital Program and Related Expenses Certificate of Insurance*, page 20, for more information).
- Inpatient hospital facility charges (when Hospital Program benefits have been exhausted).
- Laboratory services (including pathology).
- Nutritional/diabetic counseling.
- Occupational therapy.
- Orthotics and prosthetics.
- Pharmaceutical Products or Devices administered by Your Health Care Professional.
- Physical therapy.
- Pulmonary rehabilitation.
- Respiratory therapy.
- Speech therapy.

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.
- Pharmaceutical Products or Devices administered by Your Health Care Professional.

U. **Physicians** – Services of Physicians and other Providers who perform Covered Medical Services are covered. If You receive services in connection with covered inpatient or outpatient services at an Empire Plan Network Hospital or Ambulatory Surgical Center, 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. Nonparticipating Health Care Professionals must get Your formal consent in order for You to be held responsible for expenses when You receive services at an Empire Plan Network Hospital or Outpatient Surgical Location (also known as an Ambulatory Surgical Center).

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 92, for more information about surprise bills or call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 151) for more information.

Replace the following re-lettered items:

A. **Anesthesiology, Radiology and Pathology** – If You receive anesthesia, radiology or pathology services in connection with covered inpatient or outpatient Hospital services at an Empire Plan Network Hospital and The Empire Plan provides Your Primary Coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be covered at no cost to You by the Medical/Surgical Program.

E. **Effective January 1, 2020, Emergency Services** – You are covered for Emergency Services that are performed to treat Your emergency condition in a Hospital or freestanding emergency department. 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 covered at no cost to You by the Medical/Surgical Program.

Services that are provided by other specialty Physicians or other Providers in a Hospital emergency department are covered at no cost to You.

If the Emergency Services, including inpatient services when admitted through the emergency department within New York State, are provided by other Nonparticipating Providers (e.g., surgeons), the charges will be covered at no cost to You.

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 92, for more information about surprise bills or call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 151) for more information.

G. **Gender Affirmation Treatment** – Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery is covered when Your behavioral health provider, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a written psychological assessment documenting that You have a diagnosis of gender dysphoria, the capacity to make a fully informed decision and to consent for treatment and are at least 18 years of age. **Effective May 13, 2021**, consideration of gender affirming chest procedures in individuals under 18 years of age may be requested.

Any other associated surgeries, services and procedures, including those done 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, who must be licensed by the state in which they practice and acting within the scope of their practice, provides a determination of Medical Necessity and confirms that You have a diagnosis of gender dysphoria, have the capacity to make a fully-informed decision and consent for treatment and are 18 years of age or older. While not required, a Predetermination review, also known as a preservice claim determination, is available (see *Preservice claim determinations*, page 90, for more information).

AH. **Surgery** – You are covered for the services of a Physician or other Provider for surgery, including post-operative care, under the Basic Medical Program when not covered elsewhere by the Plan. There is no separate reimbursement for a Provider's use of an operating room in the Provider's office.

Multiple surgical procedures performed during the same operative session may be subject to a reduction in reimbursement. Multiple surgical procedures shall be reimbursed in an amount not less than the Usual and Customary Rate for the most expensive procedure performed. Less expensive procedures shall be reimbursed in an amount at least equal to 50 percent of the Usual and Customary Rate for these secondary procedures. You will be responsible for amounts charged by a Provider in excess of this rate.

- **Assistant Surgery** – You are covered when it is Medically Necessary for Your surgery to have an assistant during a procedure(s) for a Provider who is legally licensed by the state to act as an assistant for surgery. If You receive assistant surgery services in connection with covered inpatient or outpatient services at an Empire Plan Network Hospital or Ambulatory Surgical Center, covered

charges billed separately for care provided by assistant surgeons will be paid with no cost to You by the Medical/Surgical Program. Assistant surgery services at an out-of-network Hospital are subject to Deductible and Coinsurance.

- **Co-Surgery/Team Surgery** – You are covered when it is Medically Necessary for Your surgery to have Co-Surgery or Team Surgery for certain procedures.

When You use a Participating Provider, You are responsible only for any applicable Copayment(s).

Medical/Surgical Program General Provisions

Exclusions and limitations

Replace item H. **Family Member Provided Services** *with the following:*

Services, supplies or Pharmaceutical Products or Devices provided by Your parent, sibling, spouse/domestic partner, children or to Yourself.

How, When and Where to Submit Claims

Fraud

Rename this section **Fraud and Abusive Billing**.

Add the following paragraph to the end of the section:

The Medical/Surgical Program has processes to review claims before and after payment to detect fraud and abusive billing. Enrollees seeking services from Nonparticipating Providers could be balance billed by the Nonparticipating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Miscellaneous Provisions

Protection from Surprise Bills

Replace the paragraph with the following:

Federal and New York State law protects patients from being responsible for paying the full charge for surprise bills. Under these laws, patients receive in-network benefits for any bill deemed to be a surprise bill.

What is a surprise bill?

Replace this section with the following:

When You receive services from a Nonparticipating Health Care Professional, the bill You receive for those services is a surprise bill under the following circumstances:

Anywhere in the United States/U.S. Territories:

- You received services at a network Hospital or Ambulatory Surgical Center and Nonparticipating Health Care Professional charges are billed separately for anesthesiology, pathology, radiology and neonatology; care provided by assistant surgeons, hospitalists and intensivists; and diagnostic services (including radiology and laboratory services).
- You received other services at a network Hospital or Ambulatory Surgical Center and a Participating Health Care Professional was not available.
- You received other services at a network Hospital or Ambulatory Surgical Center and You did not sign a consent form with the Nonparticipating Health Care Professional agreeing to be financially responsible beyond Your network copayment.

Within New York State:

- A Participating Health Care Professional sends a specimen taken from the patient in the office to a Nonparticipating laboratory or pathologist without Your explicit written consent.
- Unforeseen medical circumstances arose at the time the health care services were provided.
- A Nonparticipating Health Care Professional provided services without Your knowledge in the Participating Health Care Professional's office or practice during the same visit.

Add the following new section before ***Additional Information****:*

Participating Provider Directory Protections

You are only responsible for any in-network Copayment that would apply to the Covered Services, and You are not responsible for any Nonparticipating Provider charges that exceed Your in-network Copayment, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in the online Provider directory.
- The printed Provider directory listing the Provider as a Participating Provider is incorrect as of its date of publication.
- The Program Administrator sends You a written response that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider. You have the option to receive the response in printed letter or electronic letter format (i.e., email).
- The Program Administrator does not send You a written response within one business day of Your telephone request for network status information. You have the option to receive the response in printed letter or electronic letter format (i.e., email).

Additional Information

Replace this section with the following:

You will be held harmless for any Nonparticipating Health Care Professional charges for surprise bills that exceed Your network Copayment. In such cases, the Nonparticipating Health Care Professional may only bill You for Your network Copayment.

Independent dispute resolution process

Replace this section with the following:

Either the Medical/Surgical Program or a Nonparticipating Health Care Professional may submit a dispute involving a surprise bill to an independent dispute resolution (IDR) entity assigned by the applicable regulator as follows:

- For services rendered at a participating Hospital, freestanding emergency department or Ambulatory Surgical Center, the Provider may choose to enter into a fee negotiation by submitting to our online Provider portal at www.uhcprovider.com. The Provider may also submit an IDR request to the federal IDR portal at https://nsa-idr.cms.gov/paymentdisputes/s/.
- For services rendered in a Participating Provider's office or a specimen referred by a Participating Provider's office, if the Nonparticipating Health Care Professional does not agree with the Medical/Surgical Program Administrator's surprise bill allowance, the Health Care Professional may submit a dispute by completing a provider IDR application form from www.dfs.ny.gov/IDR and sending it to the New York State Department of Financial Services. You will be held responsible for only the applicable Copayment. No action is required on Your part.

The IDR entity will determine whether the Medical/Surgical Program's payment or the Health Care Professional's charge is reasonable within 30 days of receiving the dispute. In either case, You will only be responsible for any applicable network Copayment.

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.

Meaning of Terms Used

Replace item AH. with the following:

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.
- **Effective September 1, 2021**, a licensed clinical social worker in New York State. 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) who 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.

What is Covered Under the MHSU Program

Outpatient Services

Replace the second sentence of item D. **Family Sessions** *with the following:*

When the patient is participating in a Structured Outpatient substance use Rehabilitation Program, up to 20 family sessions (per Calendar Year) for family members of the patient covered under the same Empire Plan enrollment are covered by the Program.

Empire Plan Prescription Drug Program

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

Meaning of Terms Used

Replace item J. with the following:

Excluded Drug is a drug that is excluded from coverage under this Program's Formulary or plan design. This Program will provide no benefit for a drug that is excluded from the plan design, 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 a drug that is excluded from the Formulary.

Your Benefits and Responsibilities

Copayments

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

Information on preventive medications that are available without cost sharing is available in *The Empire Plan Preventive Care Coverage Guide* or, **effective January 1, 2020**, in the Advanced Flexible Comprehensive Formulary, which can be found on NYSHIP Online (see *Contact Information*, page 151). From the NYSHIP Online homepage, select Using Your Benefits and then Empire Plan Formulary Drug Lists.

Prior authorization required for certain drugs

Replace the second and third paragraphs with the following:

Drugs may have utilization management (i.e., age or quantity limit) requirements. For a full list, **effective January 1, 2020**, see the Advanced Flexible Comprehensive Formulary on NYSHIP Online (see *Contact Information*, page 151). From the NYSHIP Online homepage, select Using Your Benefits and then Empire Plan Formulary Drug Lists. Compound Drugs that have a claim cost to the Program that exceeds $200 will require prior authorization under this Program. This list of drugs may be updated no more than quarterly.

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 Prescription Drug Program or go to NYSHIP Online (see *Contact Information*, page 151). From the NYSHIP Online homepage, select Using Your Benefits and then Prior Authorization Drug List. This list may be updated no more than quarterly.

Specialty Pharmacy Program

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

The Empire Plan Specialty Drug/Medication list may be updated no more than quarterly.

What is covered

Delete the following and re-letter the remaining items:

O. Bowel preparation products for colorectal cancer screenings that are FDA-approved Prescription drugs and bear the legend "Rx Only" or are recommended for preventive services under the Patient Protection and Affordable Care Act (PPACA). PPACA preventive services recommendations can be found at www.uspreventiveservicestaskforce.org.

Replace the following items:

F. Oral, injectable or surgically implanted contraceptives, diaphragms, vaginal pH modulators (**effective May 15, 2022**) and contraceptive devices that bear the legend "Rx Only," or are recommended for preventive services without cost sharing under the Patient Protection and Affordable Care Act (PPACA), including certain over-the-counter (OTC) products with a Prescription. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over the counter. Women's preventive services guidelines can be found at www.hrsa.gov/womens-guidelines.

N. Certain preventive vaccinations in accordance with the Patient Protection and Affordable Care Act (PPACA) or statutory mandates, administered at a Vaccination Network Pharmacy, will be covered at no cost. The covered preventive vaccines are: influenza (flu), pneumococcal (pneumonia), meningococcal (meningitis), herpes zoster* (shingles), COVID-19, and **effective January 30, 2022**, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), measles, mumps, rubella, tetanus, diphtheria, pertussis and varicella (chickenpox).

* **Effective July 1, 2022**, Shingrix® is paid in full for enrollees and dependents age 19 and older.

Replace the following re-lettered item:

P. Pre-Exposure Prophylaxis (PrEP) and, **effective December 21, 2022**, Post-Exposure Prophylaxis (PEP), when prescribed for enrollees who are at high risk of acquiring HIV.

Add the following:

Q. Certain diabetic supplies including needles, syringes, alcohol swabs and gauze obtained at a network pharmacy. These supplies will still be available through the Home Care Advocacy Program (HCAP).

Exclusions and Limitations

Replace the following items:

P. Prescription drug products excluded from the Formulary or plan design.

Q. **Effective January 1, 2019**, drug(s) that have no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that:

- Contain an active ingredient available in or are therapeutically equivalent to another drug covered in the class,
- Contain an active ingredient which is a modified version of or are therapeutically equivalent to another covered Prescription Drug Product or
- Are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.

How to Use Your Empire Plan Prescription Drug Program

Using the Empire Plan Advanced Flexible Formulary drug list

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

For a complete list, see the Advanced Flexible Comprehensive Formulary on NYSHIP Online. This list may be updated no more than quarterly, and exclusions may only be done once a year on January 1.

Coverage for preventive vaccines administered in a Vaccination Network Pharmacy

Replace the last sentence with the following:

The following preventive vaccines are covered: influenza (flu), pneumococcal (pneumonia), meningococcal (meningitis), herpes zoster (shingles), COVID-19, and **effective January 30, 2022**, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), measles, mumps, rubella, tetanus, diphtheria, pertussis and varicella (chickenpox).

Replace the second and third bullets of the **Notes** *section with the following:*

- New York State restricts Pharmacists from administering vaccines to anyone younger than 18, with the exception of the influenza vaccine and, **effective January 5, 2021**, the COVID-19 vaccine. Pharmacists may administer the influenza vaccine to persons two years of age and older and, under the Public Readiness and Emergency Preparedness (PREP) Act, **effective August 24, 2020**, Advisory Committee on Immunization Practices (ACIP) recommended vaccines to persons three years of age and older.
- **Effective July 1, 2022**, the no-copayment benefit for Shingrix® applies to enrollees and dependents age 19 and older.

Contact Information

The Empire Plan

PRESS OR SAY 1

Medical/Surgical Program

Administered by UnitedHealthcare

Managed Physical Medicine Program appeals

Administered by Managed Physical Network, Inc. (MPN)

Replace the second paragraph with the following:

Fax: 866-648-7828

PRESS OR SAY 2

Hospital Program

Administered by Empire BlueCross

Replace the fourth paragraph with the following:

TTY: 711

Replace the seventh paragraph with the following:

Claims submission fax: 866-829-2395

Claims submission online: www.empireblue.com/nys/resources-forms