JANUARY 1, 2025

EMPIRE PLAN CERTIFICATE AMENDMENTS

NEW YORK STATE HEALTH INSURANCE PROGRAM

COUNCIL 82

For employees of the State of New York
represented by Council 82 (C-82),
their covered dependents, COBRA enrollees
and Young Adult Option enrollees.

This document describes
all negotiated benefit changes
effective January 1, 2025, and all other
benefit changes effective January 1, 2024,
through January 1, 2025.

NEW YORK STATE

Department of Civil Service
The Empire Plan

TABLE OF CONTENTS

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, 2025****.*

Empire Plan Certificate of Insurance

Combined Out-of-Pocket Limits

Replace this section with the following:

PPACA sets new annual amounts that limit total network out-of-pocket costs and they apply unless the Plan sets lower limits. As a result of collectively bargained changes, Your Plan's out-of-pocket limits are lower than those required under federal PPACA provisions. Limits are determined by the amount of Your negotiated salary percentage increase from the prior year.

In-Network Out-of-Pocket Limit

Replace this section with the following:

Effective January 1, 2025, the annual maximum out-of-pocket limit for in-network expenses is $4,000 for Individual coverage and $8,000 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Use and Prescription Drug Programs as follows:

Individual coverage

- $2,600 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $1,400 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Family coverage

- $5,200 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
  - The $2,600 Individual coverage limit applies to each Plan enrollee/dependent with Family coverage; the maximum amount of $5,200 applies for all enrollees combined
- $2,800 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)
  - The $1,400 Individual coverage limit applies to each Plan enrollee/dependent with Family coverage; the maximum amount of $2,800 applies for all enrollees combined

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

Replace the last sentence of the second bullet after **You must call** *with the following:*

This includes admission if You were scheduled for outpatient surgery and are admitted to the hospital due to a complication (see *Hospital admission*, pages 12 and 13, for definitions of "emergency," "urgent" and "maternity" admissions).

Replace the last paragraph with the following:

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.
- If You are receiving observation care (see *Outpatient Hospital Care*, page 19, for observation care).

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

A. Preadmission certification for hospital admission

Replace the first paragraph after **You must call** *with the following:*

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.
- If You are receiving observation care (see *Outpatient Hospital Care*, page 19, for observation care).

D. Prospective Procedure Review

Replace the first paragraph with the following:

To receive maximum Empire Plan benefits, You must call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 154) if You or one of Your covered dependents is scheduled for an elective magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT) scan, positron emission tomography (PET) scan or nuclear medicine test, unless You are having the test as an inpatient in a hospital or as part of an emergency department visit.

There are penalties for not complying with the Prospective Procedure Review requirements

*Replace both references to "*usual and customary rate*" in the third bullet with "*allowed amount.*"*

F. Building Healthy Families Program

Replace the first two sentences with the following:

The Building Healthy Families (BHF) Program (formerly the Future Moms Program) is a voluntary Empire Plan Benefits Management Program that provides support and resources for You and Your family's unique path to parenthood, from pre-conception to pregnancy, postpartum care and parenting support.

Empire Plan Hospital Program

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

Benefits Management Program

Hospital admission

Replace the third sentence of the first **Maternity Admissions** *paragraph with the following:*

Admissions for incomplete abortion, toxemia, ectopic pregnancy or any other complication or reason other than for the delivery of your baby are not considered maternity admissions.

Inpatient Hospital Care

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

Air ambulance service (fixed wing and rotary wing). Coverage for network and non-network 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.

Covered medical expenses for network and non-network ambulance services include the following:

- Commercial air ambulance charges that are not owned and operated by a hospital, subject to a $70 copayment. These amounts are not subject to coinsurance.
- Ambulance service when the ambulance service is owned and operated by a hospital is covered in full and not subject to copayment or coinsurance.

For information regarding ground ambulance providers, see item J. in *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, page 68.

Outpatient Hospital Care

Add the following as the last sentence to the **Infusion Therapy** *bullet:*

For more information on infusions administered outside of a hospital setting, see *Site of Care Program for Infusions*, page 20.

Replace the **Hospital Extension Clinic** *bullet with the following:*

- A hospital extension clinic is a clinic that is owned and operated by a hospital. When You see a physician or receive services at a hospital extension clinic, You are being treated at a hospital-owned facility, even if the location where You receive services is located miles away from the main hospital campus or in Your physician's office. If You go to a hospital extension clinic for an office visit, You can be responsible for a Medical/Surgical Program (professional services) copayment. You will not be responsible for facility fee charges or facility fee copayments. However, if You receive additional services, such as laboratory or radiology, You can also be responsible for a Hospital Program (outpatient facility) copayment.

Copayment for outpatient hospital services

Replace the first and second paragraphs with the following:

Except as noted, You must pay a $95 copayment for outpatient surgical expenses and one $50 copayment per provider, per date of service, for diagnostic radiology and diagnostic laboratory tests at a Network Facility or the greater of either 10% of charges or $75 at a Non-Network Facility. Hospitals may require payment of this charge at the time of service.

Add the following new section before **Telemedicine Benefit***:*

Site of Care Program for Infusions

If You are or will be receiving infusions, except those used to treat cancer or hemophilia, in an outpatient hospital setting, the Hospital Program will determine if the hospital setting is clinically appropriate for Your infusions. If the outpatient hospital setting is not clinically appropriate, the Hospital Program will work with Your doctor and the Medical/Surgical Program to find an alternate setting for Your infusion therapy, which can include a freestanding infusion suite, Your doctor's office or Your home. If Your infusion is transitioned to an alternate setting such as a network freestanding infusion suite, Your network doctor's office or Your home, the Medical/Surgical Program and Prescription Drug Program copayments for Your infusion therapy will be waived. In addition, if You receive infusions in an alternate setting under the Medical/Surgical Program (see *Section III: The Empire Plan Medical/Surgical Program Certificate of Insurance*, item R., page 58, and item E., page 75) for a drug included in the Site of Care Program, the copayment for the infusion under the Medical/Surgical Program and the Prescription Drug Program will be waived. For the most up-to-date Site of Care Program for Infusions Drug List, go to anthembluecross.com/nys and choose "Plans" and then "Resources & Forms." This Program is for Empire Plan-primary enrollees only.

Telemedicine Benefit

LiveHealth Online

The following benefit was made permanent:

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 anthembluecross.com/nys and select the link to "LiveHealth Online." When registering, select "Anthem Blue Cross" 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 154) for assistance with accessing LiveHealth Online.

Hospital Program General Provisions

Exclusions and limitations

What is not covered

Replace item J. **Medicare** *with the following:*

When eligible for Medicare coverage that is primary to the Plan, i.e., when you retire, You must enroll in Medicare and file for all benefits available to You under Medicare (see *If You Qualify for Medicare*, page 33, for further information). Failure to do so will result in payment being reduced by the amount available to You under Medicare.

Empire Plan Medical/Surgical Program

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

Plan Overview

If You choose the Basic Medical Program (a Nonparticipating Provider)

Replace the second and third paragraphs with the following:

The Empire Plan reimburses You either 80% of the Allowed Amount for Covered Services, supplies and/or Pharmaceutical Products or Devices or the actual billed charges, whichever is less.

You pay the remaining 20% (Coinsurance) until the covered individual or dependent children combined have met the Coinsurance maximum. You also pay any charges above the Allowed Amount.

Basic Medical (Nonparticipating Providers)

Replace the third sentence with the following:

You are liable for an annual Deductible, for a percentage of Covered Medical Expenses in excess of the Deductible, for any charges above the Allowed Amount and for any penalties incurred under the Benefits Management Program.

Definitions

Delete the following from this list: **Scheduled Pharmaceutical Amount** *and* **Usual and Customary Rate**.

Add the following and re-letter the list:

A. **Allowed Amount** means the maximum amount paid for the services or supplies covered under the Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. If Your Nonparticipating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Deductible or Coinsurance requirements.

   Refer to the *Basic Medical Program* section, page 63, of this *Certificate* for the Allowed Amount for Nonparticipating Providers.

AR. An **Office-Based Surgical Practice** is a Physician's practice that is accredited under New York State law to perform office-based surgery. An Office-Based Surgical Practice is not a Facility (see item U., page 49).

*Replace all instances of "*Usual and Customary Rate or Scheduled Pharmaceutical Amount*" with "*Allowed Amount*" in re-lettered items* H. **Coinsurance** *and* I. **Combined Annual Coinsurance Maximum**.

*Replace all instances of "*Usual and Customary Rate or Scheduled Pharmaceutical Amount*" and "*Usual and Customary Rate*" with "*Allowed Amount*" in re-lettered item* O. **Covered Percentage**.

Participating Provider Program

Replace this section with the following:

The Participating Provider Program of The Empire Plan is described in this portion of the *Certificate*.

When You use a Participating Provider, You pay only applicable Copayments. Not all services are subject to Copayments, and You pay a maximum of one Copayment per visit for all services (office visits, office surgery, laboratory services and radiology services) billed by the same Provider. If a laboratory test and/or radiology test is sent to an outside Provider, an additional Copayment may apply.

Except as noted, Your Copayment is $25. After You pay any applicable Copayment, charges for these services will be paid directly to the Participating Provider in accordance with the Program's Schedule of Allowances. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

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

Replace this section with the following:

You pay only a single $25 Copayment per visit for services billed by the same Provider. These services include office visits, home visits, surgical procedures performed during an office visit, radiology services, diagnostic laboratory services and visits to a cardiac rehabilitation center or Convenience Care Clinic when they are covered under the Participating Provider Program. Charges for hospital facility fees are not covered under the Medical/Surgical Program; please refer to *Hospital Extension Clinic* on page 19.

You pay a maximum of two $30 Copayments per **Urgent Care Clinic** visit. See *Urgent Care Center*, page 60, for more information about Urgent Care coverage under the Participating Provider Program, including Copayments. You pay only Your $50 Copayment for Facility charges, including anesthesiology, at a **participating outpatient surgical location**. There is no cost to You for some services covered under the Participating Provider Program, such as services You receive for preventive care as required by the Patient Protection and Affordable Care Act (PPACA).

Combined out-of-pocket limit

Replace this section with the following:

PPACA sets new annual amounts that limit total network out-of-pocket costs and they apply unless the Plan sets lower limits. As a result of collectively bargained changes, Your Plan's out-of-pocket limits are lower than those required under federal PPACA provisions. Limits are determined by the amount of your negotiated salary percentage increase from the prior year.

In-network out-of-pocket limit

Replace this section with the following:

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

Individual coverage:

- $2,600 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs

Family coverage:

- $5,200 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs
  - The $2,600 Individual coverage limit applies for each Plan enrollee/dependent with Family coverage; the maximum amount of $5,200 applies for all enrollees combined

What is covered under the Participating Provider Program

Add the following and re-letter the list:

A. **Acupuncture** – You are covered, subject to Copayment, for acupuncture services rendered by a Health Care Professional licensed to provide such services.

J. **Human Donor Milk** – You are covered, subject to Copayment, for the use of pasteurized donor human milk, which may include fortifiers, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breastfeeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breastfeeding despite optimal lactation support. An infant must have a documented birth weight of less than one thousand five hundred grams or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

Add the following bullet after the last paragraph in re-lettered item H. **Diagnostic Laboratory and Radiology***:*

- **Biomarker Precision Medical Testing** – You are covered, subject to Copayment, for biomarker precision medical testing, which includes tests that identify specific biological markers in a patient's tissue, blood or other bodily fluids.

Replace re-lettered item F. **Diabetes Education Centers** *with the following:*

If You have a diagnosis of diabetes, You are covered for visits for self-management education, subject to a single $25 Copayment.

Replace the second bullet of re-lettered item X. **Reconstructive Surgery** *with the following:*

- Reconstructive breast or chest wall surgery following a Medically Necessary mastectomy including:
  - Surgery and reconstruction of the remaining breast or chest wall to produce a symmetrical appearance following the mastectomy. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute.
  - Tattooing of the nipple-areolar complex when the procedure is performed by a licensed Health Care Professional working within their scope of practice.

Replace re-lettered item AB. **Speech Therapy** *with the following:*

You are covered, subject to a single $25 Copayment, for the services of a state licensed or certified speech therapist or speech-language pathologist.

Replace the last sentence of the first paragraph of re-lettered item AC. **Surgery** *with the following:*

There is no separate reimbursement for a Provider's use of an operating room in the Provider's office (see *Exclusions and limitations*, item V., page 85).

Replace re-lettered item AE. **Urgent Care Center** *with the following:*

Services received at an Urgent Care Center that has an agreement in effect with the Medical/Surgical Program on the date of Your visit are covered, subject to applicable Copayments. Not all services are subject to Copayments and You pay a maximum of two Copayments per visit for services billed by the same Participating Provider:

- One $30 Copayment applies to charges for a visit and/or surgery.
- One $30 Copayment applies to charges for laboratory and/or radiology services provided at the same visit. If a laboratory test and/or radiology test is sent to an outside Participating Provider, an additional Copayment(s) will apply.

Preventive Care

Replace the first sentence of the **Colon Cancer Screenings** *bullet with the following:*

Colon cancer screenings, including all colon cancer examinations and laboratory tests, are covered for enrollees age 45 through 75 in accordance with the USPSTF and any additional screenings recommended by the American Cancer Society for average risk individuals.

Replace the last sentence of the **Well-Baby and Well-Child Care** *bullet with the following:*

This benefit is provided to enrollees from birth up to age 19 and is not subject to Copayment.

Basic Medical Program

Replace the third paragraph and four bullets with the following:

Allowed Amount

The Allowed Amount for Nonparticipating Providers is determined by the Medical/Surgical Program Administrator (currently UnitedHealthcare) as follows:

- Allowed Amounts are determined based on 275% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
- When a rate is not published by CMS for the service, an available gap methodology as determined by the Medical/Surgical Program Administrator is used to produce a rate for the service as follows:
  - For services other than Pharmaceutical Products or Devices, the Medical/Surgical Program Administrator uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a Provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, a comparable scale(s) will be used. UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Go to myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products or Devices, the Medical/Surgical Program Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its *Red Book*) or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
  - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network Providers for the same or similar service.
  - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the Provider's billed charge.

Updates to the CMS published rate data are made on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

You can estimate the anticipated out-of-pocket cost for Nonparticipating Provider services by contacting Your Provider for the amount that will be charged and then going to myuhc.com to obtain a cost estimate.

Note: Nonparticipating Providers may bill You for any difference between the Provider's billed charges and the Allowed Amount described here. This includes facility-based, nonancillary services when notice and consent are satisfied as described under section 2799B-2(d) of the Public Health Service Act.

Basic Medical Provider Discount Program

You may have access through the Empire Plan Basic Medical Provider Discount Program (MultiPlan) to Nonparticipating Providers who have agreed to discount their charges for covered Basic Medical expenses. Your 20% Coinsurance may be based on a discounted fee, rather than the Allowed Amount, if:

- The Empire Plan is Your Primary Coverage,
- You receive covered Basic Medical services from the Nonparticipating Provider,
- The discounted fee is lower than the Allowed Amount and
- You have met Your Combined Annual Deductible.

*Replace "*Basic Medical Usual and Customary Rate*" with "*Allowed Amount*" in the first sentence after* **When the Basic Medical Provider Discount Program Allowable Amount is Lesser and the Discount Applies**.

*Replace "*Basic Medical Usual and Customary Rate*" with "*Allowed Amount*" in the first sentence after* **When the Basic Medical Allowable Amount is Lesser and the Basic Medical Benefit Applies**.

Assignment of benefits to a Nonparticipating Provider is not permitted

Rename this section **Assignment of payment to a Nonparticipating Provider is permitted** *and replace with the following:*

Effective January 1, 2024, enrollees and covered dependents who obtain services from Nonparticipating Providers under the Medical/Surgical Program may opt to have The Empire Plan pay covered expenses to such Providers directly. To choose this option, sign the "Assignment of Benefits" field to authorize payment to Your Provider when submitting Your paper or electronic claim form. If Your claim form indicates that You paid in full or You do not select the "Assignment of Benefits" option, payment of covered expenses will be issued to You and You will be responsible for paying the Provider directly. For surprise bills, any payment due will always be assigned to Your Provider (see *Miscellaneous Provisions*, page 93, for more information about surprise bills).

If this direct payment to a Nonparticipating Provider is made, The Empire Plan's obligation to You with respect to such benefits is extinguished by such payment. If any payment of Your benefits is made to a Provider as a convenience to You, the Medical/Surgical Program Administrator will treat You, rather than the Provider, as the beneficiary of Your claim for benefits, and The Empire Plan reserves the right to offset any benefits to be paid to a Provider by any amounts that the Provider owes The Empire Plan pursuant to recovery of overpayments and subrogation.

Any such payment to a Provider:

- Is **not** an assignment or waiver of Your benefits under the Plan or any legal or equitable right to institute any proceeding relating to Your benefits and
- Shall **not** prevent the Plan or Medical/Surgical Program from asserting that any purported assignment of benefits under the Plan is invalid and prohibited.

Assignment of benefits is not allowed/permitted. Other than assignment of payment, You may not assign, transfer or in any way convey Your rights under the Plan, legal rights or any cause of action related to Your coverage under the Plan to a Provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Medical/Surgical Program or its affiliates liable for payments to a Provider or to a third party to whom You may be liable for payments of benefits.

You must meet a Deductible and pay 20% Coinsurance when You choose Nonparticipating Providers

Replace the second bullet with the following:

- After the Deductible, Covered Medical Expenses are considered for payment. The Medical/Surgical Program Administrator will reimburse You for 80% of the Allowed Amount for Covered Services, supplies and/or Pharmaceutical Products or Devices or actual billed charges, whichever is less. You pay the balance of 20% (Coinsurance) and any charges above the Allowed Amount. The Covered Percentage becomes 100% of the Allowed Amount once each combined Coinsurance amount exceeds the combined Coinsurance maximum in a Calendar Year.

Replace item B. **Coverage** *with the following:*

The Medical/Surgical Program Administrator will pay **Basic Medical benefits** to the extent Covered Medical Expenses in a Calendar Year **exceed the Combined Annual Deductible and Combined Annual Coinsurance Maximum, up to the Allowed Amount**.

Replace item C. **Covered Basic Medical Expenses** *with the following:*

Covered Medical Expenses under the Basic Medical Program are defined as the Allowed Amount for Covered Medical Services performed or supplies provided by a Health Care Professional or the Allowed Amount for Pharmaceutical Products or Devices provided by a Health Care Professional, except as otherwise provided below, due to Your sickness, injury or pregnancy. These services, supplies and Pharmaceutical Products or Devices must be Medically Necessary as defined under *Definitions*, item AO., page 50. No more than the Allowed Amount for medical services, supplies and Pharmaceutical Products or Devices will be covered by the Plan.

Covered Medical Expenses under the Basic Medical Program are also subject to the definition of Covered Medical Expenses as stated under *Definitions*, item N., page 47.

How to estimate Nonparticipating Provider costs

Replace this section with the following:

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

Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of all charges for the particular health care service performed by a Provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent.

For The Empire Plan, FAIR Health® is a nonprofit organization approved by the Department of Financial Services for the State of New York as a benchmarking database. To determine the usual and customary rate for these services in Your geographic area or ZIP Code, go to fairhealthconsumer.org.

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

Add the following and re-letter the list:

A. **Acupuncture** – You are covered for up to 20 visits per Calendar Year for acupuncture services, subject to Deductible and Coinsurance, when rendered by a Health Care Professional licensed to provide such services.

C. **Biomarker Precision Medical Testing** – You are covered, subject to Deductible and Coinsurance, for biomarker precision medical testing, which includes tests that identify specific biological markers in a patient's tissue, blood or other bodily fluids.

N. **Human Donor Milk** – You are covered, subject to Deductible and Coinsurance, for the use of pasteurized donor human milk, which may include fortifiers, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breastfeeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breastfeeding despite optimal lactation support. An infant must have a documented birth weight of less than one thousand five hundred grams or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

T. **Medical Massage Therapy** – You are covered for medical massage therapy services, subject to Deductible and Coinsurance, up to a maximum of 20 visits per Calendar Year. Services must be rendered by a Health Care Professional licensed to provide such services. Visits to a network Managed Physical Medicine Provider do not generally count toward the 20-visit limit. See *Managed Physical Medicine Program*, page 78, for coverage information on other manual therapies.

Replace re-lettered item Q. **Mastectomy Bras** *with the following:*

When prescribed by a Health Care Professional, mastectomy bras, including replacements when functionally necessary, are covered at no additional cost to You. This benefit is not subject to Deductible or Coinsurance.

Replace re-lettered item AD. **Reconstructive Surgery** *with the following:*

You are covered for reconstructive surgery under the same conditions as the Participating Provider Program, subject to Deductible and Coinsurance.

*Replace "*Usual and Customary Rate*" with "*Allowed Amount*" in re-lettered item* AL. **Surgery***, and replace the last sentence of the first paragraph with the following:*

There is no separate reimbursement for a Provider's use of an operating room in the Provider's office (see *Exclusions and limitations*, item V., page 85).

Managed Physical Medicine Program

Network benefits

Replace this section with the following:

You pay a single $25 Copayment for each office visit for chiropractic treatment, physical therapy or occupational therapy when You choose a Network Provider. This includes related radiology and diagnostic laboratory services at the same visit.

$25 Copayments when You use a Network Provider

Rename this section **$25 Copayment when You use a Network Provider***.*

*Replace "*Copayments*" in the third and fourth sentences with "*Copayment*."*

Medical/Surgical Program General Provisions

Exclusions and Limitations

Add the following and re-letter the list:

A. **Adult Immunizations.** Adult preventive immunization services, supplies and/or Pharmaceutical Products or Devices provided by a Nonparticipating Provider will not be covered.

V. **Office-Based Surgical Practice Fees.** Fees billed separately from the professional service(s) for procedures or services performed by a Provider that does not meet the definition of a Facility (see *Definitions*, item U., page 49). This exclusion would not apply to services received at a Hospital or Ambulatory Surgery Center.

X. **Over-the-Counter (OTC) Non-Pharmaceutical Products or Devices.** Non-Pharmaceutical Products or Devices purchased over the counter, such as hearing aids and self-administered laboratory tests, are not covered under the Medical/Surgical Program, except as specifically covered under the Home Care Advocacy Program (HCAP) (see *What is covered* in the *Home Care Advocacy Program (HCAP)* section, page 74).

Replace re-lettered item I. **Family Member Provided Services** *with the following:*

Services, supplies or Pharmaceutical Products or Devices provided to You by You or Your immediate family member. "Immediate family member" means a child, stepchild, spouse/domestic partner, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse/domestic partner, grandchild or grandchild's spouse.

Coordination of Benefits (COB)

Replace the second sentence in item A. *with the following:*

The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the Allowed Amount for a Covered Service or Pharmaceutical Product or Device covered under both group plans.

Replace the first sentence in item C. *with the following:*

When coordination of benefits applies and The Empire Plan is secondary to other commercial coverage, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the Allowed Amount for a Covered Service or Pharmaceutical Product or Device You receive.

Impact of Medicare on the Plan

Definitions

Replace the second paragraph in item A. *with the following:*

When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal or, in some cases, state regulations rather than the Participating Provider scheduled allowances or the Allowed Amount as defined in the *Definitions* section, page 46.

Coverage

Replace the second paragraph in item A. *with the following:*

When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal or, in some cases, state regulations rather than the Participating Provider scheduled allowances or the Allowed Amount as defined in the *Definitions* section, page 46.

How, When and Where to Submit Claims

Where

Replace the last sentence with the following:

Or, You may submit digital claim forms at memberforms.uhc.com/DirectMedicalReimbursement.html.

Miscellaneous Provisions

Protection from Surprise Bills

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 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.

If you receive a surprise bill, mail a signed *Surprise Bill Certification Form* along with a copy of the bill to the Medical/Surgical Program Administrator (see *Contact Information*, page 154, for address) and the Nonparticipating Health Care Professional. To obtain the form, go to dfs.ny.gov/IDR and select "Surprise Bill Certification Form."

What is not a surprise bill?

Add the following as the second and third sentences of the first paragraph:

Services that are not considered surprise bills or emergency treatment by the Plan will be considered for coverage under the Basic Medical Program, page 63. If You disagree with the Plan's determination, You may follow the Appeal process (see *Appeals*, page 100), which includes Your right to request an External Appeal.

Recovery of overpayments and subrogation

Subrogation and reimbursement

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

New York State law also provides that, when entering into a settlement, it is presumed that You did not take any action against the Program's rights or violate any contract between You and the Program. New York State law conclusively presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which the Medical/Surgical Program provided benefits.

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.

Throughout the Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, replace all instances of "*Usual and Customary Rate*" and "*Usual and Customary charges*" with "*Allowed Amount*."*

Coverage

Replace the second bullet with the following:

- Inpatient psychiatric care

Replace the fourth bullet with the following:

- Outpatient Services, including Transcranial Magnetic Stimulation (TMS) and aftercare following hospital discharge

Replace the fifth bullet with the following:

- Inpatient Services, including residential and rehabilitation services for Substance Use Care

Replace the sixth bullet with the following:

- Substance use Structured Outpatient Program and aftercare

Meaning of Terms Used

Delete the following from this list: **Usual and Customary**.

Add the following and re-letter the list:

A. **Allowed Amount** is the amount determined for Non-Network Providers by the MHSU Program Administrator (currently Carelon Behavioral Health) as follows:

- Allowed Amounts are determined based on 275% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
- When a rate is not published by CMS for the service, an available gap methodology is used to determine a rate. When a rate for a service is not published by CMS and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

Updates to the CMS published rate data are made on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

Note: Non-Network Providers may bill You for any difference between the Provider's billed charges and the Allowed Amount described here. This includes facility-based, non-ancillary services when notice and consent are satisfied as described under section 2799B-2(d) of the Public Health Service Act.

Replace the **Note** *in re-lettered item* C. **Approved Facility** *with the following:*

Services received at an Approved Facility are subject to a Medical Necessity determination.

Replace the last sentence of re-lettered item D. **Autism Spectrum Disorder** *with the following:*

It includes the *International Classification of Diseases, Tenth Revision (ICD-10)* diagnosis of "autistic disorder."

Rename re-lettered item AP. **Structured Outpatient Rehabilitation Program** *as* **Structured Outpatient Program** *and delete all instances of "*Rehabilitation*" in the item.*

Replace the first bullet of re-lettered item AQ. **Substance Use Care** *with the following:*

- Intended to prevent, diagnose, correct, alleviate or preclude deterioration of a diagnosable condition (most current version of *International Classification of Diseases [ICD]*) that threatens life, causes pain or suffering or results in illness or infirmity.

What Is Covered Under the MHSU Program

Outpatient Services

Replace item E. *with the following:*

Substance Use Structured Outpatient Program benefits are covered.

Replace item F. *with the following:*

Psychological Testing and Evaluations are covered.

Replace the last sentence of item I. **Electroconvulsive Therapy (ECT)** *with the following:*

Prior authorization is not required for outpatient ECT.

Schedule of Benefits for Covered Services

Replace the twelfth bullet with the following:

- Partial hospitalization for mental health**

Replace the two footnotes and the last paragraph with the following:

* Precertification is not required for Office of Addiction Services and Supports–certified network facilities located within New York State if the MHSU Program Administrator is notified in accordance with the New York State Substance Use Disorder registration process.

** Precertification is not required for covered individuals at Office of Mental Health–certified network facilities located within New York State if certain requirements are met.

Mental health inpatient services for covered individuals at an Office of Mental Health facility do not require precertification if certain requirements are met, including notifying the MHSU Program Administrator within two business days of the admission.

Network Coverage for Mental Health Care and Substance Use Care

*Delete "*Rehabilitation*" in item* A.

Add the following new sections before **Exclusions and Limitations***:*

Center of Excellence for Substance Use Disorder Treatment Program

The Center of Excellence for Substance Use Disorder Treatment Program, in partnership with the Hazelden Betty Ford Foundation, provides paid-in-full coverage for substance use–related expenses received through one of the Hazelden Betty Ford Foundation's nationwide locations. If You choose to participate in the Center of Excellence for Substance Use Disorder Program, You receive enhanced benefits as detailed in this section. The enhanced benefits include travel reimbursement and a paid-in-full benefit for services covered under the Program and performed at one of the Hazelden Betty Ford Foundation's locations. Participation in the Center of Excellence for Substance Use Disorder Program is voluntary, but the enhanced benefits under the Program are available only when You have enrolled with the Center of Excellence through either the Hazelden Betty Ford Foundation or the Carelon Behavioral Health's clinical team before obtaining services. For a current list of Hazelden Betty Ford Foundation locations and the populations they serve, call The Empire Plan and choose the MHSU Program (see *Contact Information*, page 154), then select the number for the Clinical Referral Line.

What is covered

Prior authorization is required to receive paid-in-full benefits for the following services:

- Assessment prior to treatment
- Full evaluation at the provider site
- Intensive outpatient treatment and partial hospitalization
- Detoxification and residential rehabilitation
- Care coordination for transition back to home community
- Support program for children ages seven to 12 who are impacted by addiction
- Family treatment and support, including individual support services

Enrollment

To receive the paid-in-full benefit and the travel benefit, You must call The Empire Plan and choose the MHSU Program (see *Contact Information*, page 154), then select the Clinical Referral Line to enroll in the Program. You are encouraged to call and renew Your case annually.

Other benefits still available

The Center of Excellence for Substance Use Disorder Program is voluntary. If You choose not to enroll in the Program, You are still eligible for Empire Plan benefits for Your covered substance use treatment. Covered behavioral health services are available under the MHSU Program. You will have to comply with the requirements of the MHSU Program and will have to pay any applicable Deductible, Coinsurance and Copayments.

Center of Excellence Travel Allowance

When You enroll in the Center of Excellence for Substance Use Disorder Program, You will not have to make any Copayments for services performed at a qualified Center of Excellence. A travel, lodging and meal expenses benefit is available to You for travel within the United States. The travel and meals benefit is available to You and up to two travel companions, regardless of Your age, when the Facility is more than 100 miles (200 miles for airfare) from Your home. Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the United States General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. Once You arrive at Your lodging and need transportation from Your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, local ridesharing, taxi or bus fare; shuttle; parking; and tolls.

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 S. *with the following:*

Non-Preferred Drug means a Brand-Name Drug that is subject to a Level 3 copayment on the Empire Plan Advanced Flexible Formulary drug list.

Add the following as the last sentence to item W. **Prescription***:*

Refills are valid for up to one year from the date the Prescription is written, subject to applicable state and federal laws.

Your Benefits and Responsibilities

Copayments

Replace 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 in the Advanced Flexible Comprehensive Formulary, which can be found on the NYSHIP website (see *Contact Information*, page 154). From the NYSHIP homepage, select "Using Your Benefits" and then "Empire Plan Formulary Drug Lists."

Opioid treatments dispensed through retail pharmacies are subject to the applicable copayment. For opioid treatments not subject to copayment, see *Section IV: The Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, page 117.

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

Supply and coverage limits

Add the following as the last sentence of the third paragraph:

Specialty Drugs/Medications may include specialty quantity limits based on FDA dosing guidelines.

Mandatory generic substitution

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

When Your Prescription is written dispense as written (DAW) for a Brand-Name Drug that has a generic equivalent, You pay the preferred drug copayment with no Ancillary Charge or the non-preferred drug copayment plus the Ancillary Charge, not to exceed the actual cost of the drug.

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

For these drugs, You pay only the applicable copayment, which, in most cases, will be the non-preferred copayment and there is no Ancillary Charge applied.

What is covered

Add the following as the last sentence to item D.*:*

Per New York State law, covered prescription insulin drugs are not subject to a deductible, copayment, coinsurance or any other cost-sharing requirement.

Add the following as the last sentence to item F.*:*

Per New York State law, the Plan covers at least one product under each of the FDA's contraceptive categories at a $0 copayment.

Add the following as the last sentence to item K.*:*

Oral chemotherapy drugs for the treatment of cancer do not require a copayment.

How to Use Your Empire Plan Prescription Drug Program

Using the Empire Plan Advanced Flexible Formulary drug list

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

Empire Plan participating Doctors can access the Advanced Flexible Formulary drug list online.

Coverage for preventive vaccines administered in a Vaccination Network Pharmacy

Replace the first paragraph with the following:

Empire Plan-primary enrollees and covered dependents may obtain seasonal and non-seasonal preventive vaccines administered at a Vaccination Network Pharmacy with no copayment as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention or in accordance with statutory mandates.

Add the following as the first two bullets in the **Notes** *section:*

- For up-to-date information on ACIP recommendations for adult immunizations, go to cdc.gov/vaccines/hcp/imz-schedules/adult-age.html.
- For up-to-date information on ACIP recommendations for child immunizations, go to cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html.

Coordination of Benefits (COB)

Replace the last sub-bullet of the first bullet in item B. **Definitions** *with the following:*

- A governmental program (such as Medicare) or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.

Contact Information

The Empire Plan

Medical/Surgical Program

Administered by UnitedHealthcare

Replace the seventh paragraph with the following:

Claims submission online: memberforms.uhc.com/DirectMedicalReimbursement.html

Hospital Program

Administered by Anthem Blue Cross

Replace the sixth paragraph with the following:

anthembluecross.com/nys

Other Claims

Add the following after **Hospitals outside of the United States***:*

Claims submission online: bcbsglobalcore.com. To register for an account, enter code YLS and Your Empire Plan member identification number from Your Empire Plan benefit card.

Mental Health and Substance Use Program

Administered by Carelon Behavioral Health

Add the following as the seventh paragraph:

Claims submission online: carelonbh.com/empireplan/en/home/forms-and-documents#item_1