JULY 1, 2023

EMPIRE PLAN CERTIFICATE AMENDMENTS

NEW YORK STATE HEALTH INSURANCE PROGRAM

CIVIL SERVICE EMPLOYEES ASSOCIATION

For Employees of the State of New York
represented by the Civil Service
Employees Association (CSEA),
their enrolled Dependents,
COBRA Enrollees and
Young Adult Option Enrollees

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

NEW YORK STATE | Department of Civil Service
The Empire Plan

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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* ***July 1, 2023****.*

Effective March 1, 2023*, throughout the* Empire Plan Certificate*, replace all instances of "*Beacon Health Options*" with "*Carelon Behavioral Health.*"*

Effective January 1, 2024*, throughout the* Empire Plan Certificate*, replace all instances of "*Empire BlueCross*" with "*Anthem Blue Cross.*"*

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.

In-Network Out-of-Pocket Limit

Replace this section with the following:

Effective July 1, 2023, 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 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.

The Empire Plan Benefits Management Program: Benefits and Your Responsibilities

D. Prospective Procedure Review

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. Future Moms Program

Effective January 1, 2023*, rename this section* **Building Healthy Families Program**.

Replace this section and the **Future Moms Program** *section 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, the BHF Program offers help with every stage of family planning. The BHF Program can also be utilized if You are acting as a surrogate.

BHF Program features include:

- Digital tracking tools for ovulation, weight, blood pressure, due date and prenatal milestones, as well as for Your baby's movement, growth, feeding schedule and vaccinations
- Educational articles and videos for each stage of building Your family
- Breastfeeding support from a lactation consultant through LiveHealth Online
- Access to a Family Care Coach via chat, email or phone
- Support in prenatal, maternity and postpartum care for members who identify as lesbian, gay, bisexual, transgender, queer, intersex or asexual (LGBTQIA+)
- Meditation/mindfulness tools
- Unlimited digital access 24 hours a day, seven days a week
- Nurse case management for high-risk enrollees, including access to counselors and registered dietitians

For more information regarding the BHF Program, go to www.anthembluecross.com/nys and choose Care and then Health & Wellness. You can also call The Empire Plan and choose the Hospital Program (see *Contact Information*, page 153).

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

Empire Plan Hospital Program

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

Effective January 1, 2024, *replace all instances of* "Empire BlueCross" *with* "Anthem Blue Cross."

Network and Non-Network Benefits

Replace items A. and B. under the **Network Benefits at a Non-Network Hospital/Facility** *bullet with the following:*

A. When no Network Facility is available within a 30-mile radius or 30-minute travel time from Your home address.

B. When no Network Facility is available within a 30-mile radius or 30-minute travel time from Your home address that can provide the covered services You require.

Outpatient Hospital Care

Add the following bullet after the **Chemotherapy and Radiation Therapy** *bullet:*

- **Infusion Therapy**. The Hospital Program pays for infusion therapy ordered by Your doctor. For more information on infusions administered outside of a hospital setting, see *Site of Care Program for Infusions*, page 20.

Effective February 1, 2023, *replace the* **Hospital Extension Clinic** *bullet with the following:*

- **Hospital Extension Clinic.** Hospitals charge facility fees for outpatient services performed by employed physicians who work in hospital extension clinics. 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.

  Hospital billing policies are not always apparent regarding hospital-owned extension clinics. Professional services and facility fees can be billed separately. If services are billed separately, You can be responsible for a Medical/Surgical Program (professional services) copayment. You may also be responsible for a Hospital Program copayment even if You did not receive services in the outpatient department of a hospital or if You only had an office visit with Your provider and did not receive any other services, such as laboratory or radiology. When making an appointment, it is Your responsibility to ask the physician's office if they are a hospital extension clinic. **Note:** Medical/Surgical and Hospital Program copayments do not apply to preventive care services. For more information on preventive care services, see *The Empire Plan Preventive Care Coverage Guide* on the NYSHIP website (see *Contact Information*, page 153). From the NYSHIP homepage, select Using Your Benefits and then Current Publications.

Copayment for outpatient hospital services

Replace the first and second paragraphs with the following:

Except as noted, You must pay a $75 copayment for outpatient surgical expenses and one $40 copayment per provider, per date of service, for diagnostic radiology and diagnostic laboratory tests at a Network Facility or the greater of either 10 percent of charges or $75 at a Non-Network Facility. Hospitals may require payment of this charge at the time of service.

When copayments do not apply

Add the following sub-bullet to the end of the third bullet:

- Infusion therapy

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

Site of Care Program for Infusions

Effective July 1, 2023, if You are or will be receiving infusions for infliximab (Remicade®) or an infliximab biosimilar 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 Q., page 57, and item E., page 74) 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. **Effective January 1, 2024**, the Site of Care Program expanded to include all drug infusion therapies except those used to treat cancer or hemophilia. For the most up-to-date Site of Care Program for Infusions Drug List, go to www.anthembluecross.com/nys and choose Plans and then Resources & Forms. 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 www.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 153) for assistance with accessing LiveHealth Online.

Skilled Nursing Facility Care

Replace the second sentence with the following:

The Empire Plan does not provide skilled nursing facility benefits, even for short-term rehabilitative care, for Medicare-primary enrollees or Medicare-primary dependents.

Infertility Benefits

Fertility preservation services

Replace the second and third sentences with the following:

Standard fertility preservation services are covered when a medical treatment may directly or indirectly cause iatrogenic infertility. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

Hospital Program General Provisions

Exclusions and limitations

What is not covered

Replace the following item:

O. **Workers' Compensation.** Payment will not be made for care for any injury, condition or disease if payment is provided to You under a Workers' Compensation Law or similar legislation. Also, payments will not be made if You bring a lawsuit against the person who caused Your injury or condition and if You received money from that lawsuit and You have repaid the hospital and other medical expenses You received payment for under the Workers' Compensation Law or similar legislation.

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 percent 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 percent (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.

*Replace all instances of "*Physician or other Provider*" with "*Health Care Professional*" in re-lettered items* N. **Covered Medical Expenses or Covered Services**, AO. **Medically Necessary or Medical Necessity** *and* AS. **Pharmaceutical Product or Device**.

*Replace "*Physician*" with "*Health Care Professional*" in item* BD. **Specialist**.

Replace the following re-lettered items:

H. **Coinsurance** means the difference between the Allowed Amount and the Covered Percentage under the **Basic Medical** portion of the Plan. Coinsurance also means the difference between the network allowance and the Covered Percentage under the **Managed Physical Medicine Program** and the **Home Care Advocacy Program (HCAP)**. You pay the Coinsurance.

I. **Combined Annual Coinsurance Maximum** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each Calendar Year, after the annual Deductible has been met, for Covered Medical Expenses incurred under the Basic Medical, non-network Hospital and non-network Mental Health and Substance Use (MHSU) Programs.

   The Combined Annual Coinsurance Maximum is $3,750 for the enrollee and $3,750 for the enrolled spouse/domestic partner. All dependent children have a Combined Annual Coinsurance Maximum of $3,750.

Each $3,750 coinsurance maximum will be reduced to $1,875 per Calendar Year for employees in or equated to salary grade level six or below as of January 1 of that year.

Coinsurance amounts incurred under the Basic Medical, non-network Hospital and non-network MHSU programs are applied to the Combined Annual Coinsurance Maximum. Copayments for Participating Provider and network MHSU practitioner services also count toward the Combined Annual Coinsurance Maximum.

The annual Deductible does not count toward the Combined Annual Coinsurance Maximum. Any expenses above the Allowed Amount do not count. Copayments made to network Hospital facilities do not count toward the Combined Annual Coinsurance Maximum. Expenses for ambulance services and expenses under the Home Care Advocacy Program (HCAP), Managed Physical Medicine Program and the Benefits Management Program do not count toward the Combined Annual Coinsurance Maximum, nor do any penalties under the Benefits Management Program or HCAP.

Once the Combined Annual Coinsurance Maximum is met, Covered Medical Expenses will be reimbursed at 100 percent of the Allowed Amount, or 100 percent of the billed amount, whichever is less. You will still be responsible for any charges above the Allowed Amount and for any penalties under the Benefits Management Program.

O. **Covered Percentage**

1. Under the Participating Provider Program, the **Covered Percentage** is **100 percent** of the Schedule of Allowances, after Your Copayment.
2. Under the Basic Medical portion of this Plan, the **Covered Percentage** for Covered Medical Expenses is **80 percent** of the Allowed Amount except:
   a. As provided under *Prospective Procedure Review*, page 7; under the *Home Care Advocacy Program (HCAP)*, page 72; under *Guaranteed access* for the *Managed Physical Medicine Program*, page 78; and under *Infertility Benefits*, page 78; and
   b. The **Covered Percentage becomes 100 percent** of the Allowed Amount once the Combined Annual Coinsurance Maximum is met.
3. For infertility benefits, expenses are paid the same as for other medical conditions: The Covered Percentage for Basic Medical Program services is 80 percent of the Allowed Amount. Under the Participating Provider Program, the Covered Percentage is 100 percent of scheduled allowances after Your Copayments. However, You have no Copayment at a Center of Excellence for Infertility. Certain benefits are subject to a Lifetime Maximum as indicated in the *Infertility Benefits* section, page 80.

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. 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.

In-network out-of-pocket limit

Replace this section with the following:

Effective July 1, 2023, 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.

Rename re-lettered item L. **In-Hospital Physician's or Other Provider's Visits** *as* **In-Hospital Health Care Professional's Visits***, and replace with the following:*

L. **In-Hospital Health Care Professional's Visits** – You are covered for visits by a Health Care Professional while an inpatient in a Hospital with no Copayment if such visits are not related to surgery. Benefits for visits related to surgery are included in the scheduled amount for the surgery.

*Delete "*Physician or other*" from re-lettered item* X. **Reproductive Access to Health Care Services**.

*Delete "*or other Provider*" from re-lettered item* AB. **Surgery**.

*Replace "*Physician*" with "*Health Care Professional*" in re-lettered items* M. **Mastectomy Bras** *and* Z. **Specialist Consultations**.

*Replace "*Physician or other Provider*" with "*Health Care Professional*" in re-lettered item* N. **Maternity Care**.

Replace the following re-lettered items:

F. **Diabetes Education Centers** – If You have a diagnosis of diabetes, You are covered for visits for self-management education, subject to a single $25 Copayment.

Q. **Office and Home Visits** – You are covered for office visits and home visits by a Health Care Professional or other Provider for general medical care, diagnostic visits, treatment of illness, infusion therapy, 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 Health Care Professional 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 Health Care Professional 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 153) 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*, page 60, for more information on preventive care services. For information regarding infusion therapy, refer to the *Site of Care Program for Infusions* in *Section II: The Empire Plan Hospital Program and Related Expenses Certificate of Insurance* on page 20.

W. **Reconstructive Surgery** – You are covered, subject to Copayment, for the services of a Physician for the following:

- Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:
  - Birth defect
  - Sickness
  - Accidental injury
- 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.
- Treatment of physical complications of all stages of the mastectomy, including lymphedema.
- Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other Medically Necessary surgery.

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

Preventive Care

Replace the **Adult Immunizations** *bullet with the following:*

- **Adult Immunizations** – Adult immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention are covered and not subject to Copayment when received by a Participating Provider. There is no benefit for vaccines received from an out-of-network Provider.

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

Add the following bullet after the **Breastfeeding Support, Supplies and Counseling** *bullet:*

- **Colon Cancer Screenings** – Colon cancer screenings, including all colon cancer examinations and laboratory tests, are covered for enrollees age 45 through 75 in accordance with the greater of the USPSTF or American Cancer Society recommendations for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

  This benefit is not subject to Copayment when provided in accordance with the recommendations of the USPSTF and when performed by a Participating Provider.

Replace the second sentence of the **Family Planning and Reproductive Health Services** *bullet with the following:*

The Medical/Surgical Program covers family planning services, which consist of FDA-approved, -cleared or -granted contraceptive methods dispensed by a Health Care Professional, not otherwise covered under *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*, counseling on use of contraceptives and related topics and sterilization procedures for women.

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 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
- When a rate is not published by CMS for the service, an available gap methodology as determined by the Medical/Surgical Program Administrator is used to produce a rate for the service 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 www.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 percent 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 www.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 is 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 percent 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**.

You must meet a Deductible and pay 20 percent 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 percent 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 percent (Coinsurance) and any charges above the Allowed Amount. The Covered Percentage becomes 100 percent 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 51. 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 www.myuhc.com to obtain a cost estimate.

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

FAIR Health® is a nonprofit organization approved by the State of New York as a benchmarking database. To determine the usual and customary rate for these services in Your geographic area or ZIP code, go to www.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.

O. **Medical Massage Therapy** – You are covered for medical massage therapy services, subject to Deductible and Coinsurance, when rendered by a Health Care Professional licensed to provide such services. You are covered for a maximum of 20 medical massage therapy visits per Calendar Year. Visits to a network Managed Physical Medicine Provider do not generally count toward the 20-visit limit. See *Managed Physical Medicine Program*, page 77, for coverage information on other manual therapies.

Rename re-lettered item W. **Physicians** *as* **Physician Services***, and delete "*and other Providers*" in the first sentence.*

*Delete "*Physician or other*" from re-lettered item* AC. **Reproductive Access to Health Care Services**.

*Replace "*Physicians or other Providers*" with "*Health Care Professionals*" in re-lettered item* F. **Emergency Services**.

*Replace "*Physician or other Provider*" with "*Health Care Professional*" in re-lettered items* R. **Maternity Care** *and* T. **Modified Solid Food Products**.

*Replace "*Physician's or other Provider's*" with "*A Health Care Professional's*" in re-lettered item* AE. **Routine Newborn Child Care**.

Replace the following re-lettered items:

P. **Mastectomy Bras** – 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.

AJ. **Surgery** – You are covered for the services of a Physician 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 Allowed Amount for the most expensive procedure performed. Less expensive procedures shall be reimbursed in an amount at least equal to 50 percent of the Allowed Amount 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 in which they practice 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).

Home Care Advocacy Program (HCAP)

Replace the first paragraph with the following:

The Home Care Advocacy Program (HCAP) is The Empire Plan program for home skilled nursing services, certain Durable Medical Equipment and medical supplies that are associated with Durable Medical Equipment (see the definition for item A., *Durable Medical Equipment*, page 73). Covered home skilled nursing services do not include assistance with activities of daily living, custodial care or any other service that can be given by a less skilled person, such as a home health aide (see item D., *Skilled Nursing Services in the Home*, page 73, for exclusions). HCAP is administered by the Medical/Surgical Program Administrator.

Network coverage: Paid-in-full benefit

*Delete "*and Medijectors*" from the first and fourth sentences in the third paragraph.*

What is covered

*Replace "*Physician*" with "*Health Care Professional*" in the last sentence of the* **Diabetic Supplies** *bullet under item* B. **Medical Supplies**.

Replace the second sentence in item C. **Communication Devices** *with the following:*

Based on the formal evaluation, the rental or purchase of assistive communication devices is covered when ordered or prescribed by an authorized Health Care Professional, and recommended by a licensed speech-language pathologist, if You are unable to communicate through typical means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication.

*Replace "*Physician*" with "*Health Care Professional*" in the last sentence of item* D. **Skilled Nursing Services in the Home**.

Replace the fourth sentence in item E. **Home Infusion Therapy** *with the following:*

The services must be ordered by an authorized Health Care Professional.

Replace the first sentence in item F. **Enteral Formulas** *with the following:*

You are covered for nonprescription enteral formulas for home use under HCAP, whether administered orally or via tube feeding, for which an authorized Health Care Professional has issued a written order.

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.*"*

Infertility Benefits

Fertility preservation services

Replace the second and third sentences with the following:

Standard fertility preservation services are covered when a medical treatment may directly or indirectly cause iatrogenic infertility. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

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.

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.

Effective March 1, 2023*, replace all instances of "*Beacon Health Options*" with "*Carelon Behavioral Health*."*

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*."*

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 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
- When a rate is not published by CMS for the service, an available gap methodology 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 percent 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 is satisfied as described under section 2799B-2(d) of the Public Health Service Act.

Replace the following re-lettered item:

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

Schedule of Benefits for Covered Services

Network Coverage for Mental Health Care and Substance Use Care

Replace the **Note** *with the following:*

Note: There is no Copayment for Inpatient Services or, **effective January 1, 2023**, when receiving services for opioid treatment that includes the prescribing of agonists, such as methadone, buprenorphine or suboxone. This includes waiving of Copayments for therapy and counseling sessions related to opioid treatment programs, as well as prescriptions provided through a treatment program; however, prescriptions obtained at a retail pharmacy are still subject to the applicable Copayment (see *Section V: The Empire Plan Prescription Drug Program Certificate of Insurance*, page 134).

Copayments paid to a Network Provider count toward meeting Your Empire Plan Combined Annual Coinsurance Maximum but **do not** count toward the Combined Annual Deductible.

Your payment to the Network Provider is limited to Your Copayment. Except for the Copayment that the Network Provider obtains directly from You, a Network Provider cannot bill You directly for services You obtain as a network benefit.

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 153), 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 153), 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.

Your Benefits and Responsibilities

Copayments

Add the following as the second paragraph of the **Note***:*

Opioid treatments dispensed through retail pharmacies are subject to the applicable copayment. For opioid treatments not subject to copayment **effective January 1, 2023**, see *Section IV: The Empire Plan Mental Health and Substance Use Program Certificate of Insurance*, page 116.

What is covered

Replace the following items:

F. Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, that are FDA-approved, -cleared or -granted and as prescribed or otherwise authorized under state or federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over the counter. You may request coverage for an alternative version of a contraceptive drug, device or other product if the covered contraceptive drug, device or other product is not available or is deemed medically inadvisable, as determined by Your Doctor.

G. Coverage for abortion services includes any Prescription drug prescribed for an abortion (including Generic Drugs and Brand-Name Drugs, even if those Prescription drugs have not been approved by the FDA for abortions) that is a recognized medication for abortions in one of the following reference compendia:

- The World Health Organization (WHO) Model Lists of Essential Medicines
- The WHO abortion care guidelines
- The National Academies of Sciences, Engineering and Medicine Consensus Study Report

N. Certain preventive vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention or in accordance with statutory mandates, administered at a Vaccination Network Pharmacy, will be covered at no cost. For up-to-date information on ACIP recommendations for adult immunizations, go to www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html.

Contact Information

The Empire Plan

Medical/Surgical Program

Administered by UnitedHealthcare

Diabetic supplies (except insulin pumps and Medijectors)

Rename this section ***Diabetic supplies (except insulin pumps)****.*

Hospital Program

Administered by Anthem Blue Cross

Replace the sixth paragraph with the following:

www.anthem.com

Replace the eighth paragraph with the following:

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

Mental Health and Substance Use Program

Administered by Carelon Behavioral Health

Replace the third paragraph with the following:

TTY: 711

Replace the fifth paragraph with the following:

www.carelonbh.com/empireplan/en/home

Replace the seventh paragraph with the following:

Claims submission forms can be submitted via the MemberConnect portal:
www.memberconnect.carelonbehavioralhealth.com/mc/eMember/memberLogin.do