NEW YORK STATE | The Empire Plan

Special Report

Information about your new NYSHIP benefits effective July 1, 2024.

Empire Plan Special Report

May 2024 • NY Active (DC-37/NYSCOPBA)

New York State Health Insurance Program (NYSHIP) for Employees of New York State represented by District Council 37 (DC-37) and for Employees of New York State represented by the New York State Correctional Officers and Police Benevolent Association (NYSCOPBA), their enrolled Dependents, COBRA Enrollees with their Empire Plan benefits and Young Adult Option Enrollees

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

IN THIS REPORT

Changes Effective July 1, 2024

This *Special Report* describes changes affecting your NYSHIP Empire Plan coverage that will take effect on July 1, 2024, as a result of the recently ratified contracts between the State of New York and District Council 37 (DC-37) and the New York State Correctional Officers and Police Benevolent Association (NYSCOPBA).

They include:

- Reduced In-Network Maximum Out-of-Pocket Limits (page 4)
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- New Center of Excellence for Substance Use Disorder (page 5)
- New Reimbursement Methodology for Non-Network Claims (pages 6–7)
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Special Option Transfer Period

This publication outlines July 1, 2024 changes to your NYSHIP Empire Plan coverage. You will have the opportunity to change your NYSHIP option for the remainder of 2024 during the upcoming Special Option Transfer Period (**May 28 through June 28, 2024**). During this time, you may choose to change your plan option between The Empire Plan and a NYSHIP-approved Health Maintenance Organization (HMO) serving the area where you live or work. If you decide to change your health insurance option during this Special Option Transfer Period, see the *NYSHIP July 1, 2024 Rate Changes* publication for when your new option will take effect.

Option Information

If you are considering changing your health insurance plan, refer to the following publications:

- *Health Insurance Choices for 2024*. This guide provides a detailed comparison of NYSHIP benefits, including The Empire Plan and NYSHIP-approved HMOs, as well as the procedures for changing options. *Choices* is available online or from your Health Benefits Administrator (HBA) or the New York State Business Services Center (BSC).
- *NYSHIP Rate Changes*. This is a listing of biweekly premium contributions effective July 1, 2024, for affected enrollees in The Empire Plan and NYSHIP-approved HMOs, as well as the deadlines for making changes during the Special Option Transfer Period. The July 1, 2024 rates will be posted online and the rate flyer will be mailed to your home address in May.

You can access these publications on NYSHIP Online (see *Benefits on the Web*, page 10). From the NYSHIP Online homepage, select Health Benefits & Option Transfer and then Rates and Health Plan Choices.

How to Change Options

If you wish to change your option during the special mid-year Option Transfer Period, contact your HBA or the BSC for the *NYSHIP Health Insurance Transaction Form for NYS & PE Employees* (PS-404). Return the completed and signed form to your HBA by the **June 28, 2024** deadline. **Note:** Pre-Tax Contribution Program election changes and online option changes using MyNYSHIP will NOT be permitted during the Special Option Transfer Period.

For questions about your benefits, contact your HBA or The Empire Plan, choose the Medical/Surgical Program (see *Contact Information*, page 10) and then select the appropriate prompt for plan benefit questions.

Empire Plan Changes

July 1, 2024 Benefit Changes and Resources

This *Special Report* provides an overview of the changes that will take effect beginning in July. It is important that you understand them in order to manage your care and its cost. An informational presentation is also available to you; simply scan the QR code at the bottom of the page with your mobile device or tablet to access it. This approximately 12-minute resource is also posted on NYSHIP Online (see *Benefits on the Web*, page 10) under What's New.

Revised *At A Glance* Publication

In addition to these resources, the Empire Plan *At A Glance* publication will be updated to reflect these changes and it will be mailed to your home address in July with an updated *Out of Network Reimbursement Disclosure*. Some supplemental publications that are usually inserted with this mailing are not changing and are available online, so they will not be mailed again. Please remove the January 1, 2024 *Empire Plan Advanced Flexible Formulary* and the 2024 version of the *Preventive Care Coverage Guide* from the January 1, 2024 *At A Glance* mailing and keep them for your reference. Remember that you can find the most updated version of the formulary on NYSHIP Online under the Using Your Benefits tab.

New Empire Plan Benefit Cards

To comply with federal law, new Empire Plan benefit cards will be issued to you and your covered dependents in advance of the July 1, 2024 changes. The reduced in-network maximum out-of-pocket limits referenced on page 4 will be reflected on your new version. Please be sure to use the new card and securely destroy the old one. If you have questions about your Empire Plan benefit card, contact your Health Benefits Administrator. For questions regarding your Empire Plan benefits, call the Plan and select the prompt for the appropriate Program (see *Contact Information*, page 10).

Updated *Summary of Benefits and Coverage*

The *Summary of Benefits and Coverage* (*SBC*) is a standardized comparison document required by the Patient Protection and Affordable Care Act. It is designed to improve health insurance information

so you can better understand your coverage. Some terms used in the *SBC* are defined in the *Uniform Glossary*, a non-customized companion document to the *SBC*. The *SBC* will be updated for July 1, 2024, to reflect these benefit changes.

To view the updated *SBC* or the *Uniform Glossary* for The Empire Plan, visit www.cs.ny.gov/sbc and choose your group. To request a copy, call the Plan and choose the Medical/Surgical Program (see *Contact Information*, page 10).

Access the Presentation Using the QR Code

Open the camera on your device and scan the QR code below. Be sure that the entire code is visible. Tap the link that appears on your device screen to open the presentation. The Empire Plan July 2024 Benefit Changes Presentation works best when used with the latest versions of the following browsers: Microsoft Edge, Firefox, Safari and Chrome. If you prefer to access the presentation without using the code, go to the What's New tab on NYSHIP Online and select the posting for the presentation.

Reduced In-Network Maximum Out-of-Pocket Limits

The federal Patient Protection and Affordable Care Act sets new annual amounts that limit total network out-of-pocket costs and they apply unless the Plan sets lower limits. **Effective July 1, 2024**, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan will be reduced from $9,450 to $4,000 for Individual coverage and from $18,900 to $8,000 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Use and Prescription Drug Programs as specified in the chart below. Your in-network out-of-pocket costs, such as copayments for covered in-network services, will not exceed these amounts. Once you reach the limit, network benefits, including copayments, are covered at no cost to you.

Note: If you have already met the maximum out-of-pocket limit in effect on July 1, 2024, you will no longer be responsible for any in-network cost share for the remainder of the year. Out-of-pocket expenses incurred from January 1, 2024–June 30, 2024 will roll forward and count toward the new limits.

If you have questions about your maximum out-of-pocket limit for prescription drugs, call The Empire Plan and choose the Prescription Drug Program (see *Contact Information*, page 10). If you have questions about your limit for all other covered in-network services, choose the Medical/Surgical Program.

2024 Maximum In-Network Out-of-Pocket Limits

	January 1 – June 30, 2024			July 1 – December 31, 2024		
	Total	Prescription Drugs	All Other Covered In-Network Services, Combined	Total	Prescription Drugs	All Other Covered In-Network Services, Combined
Individual Coverage	$9,450	$3,300*	$6,150	$4,000	$1,400*	$2,600
Family Coverage	$18,900	$6,650*	$12,250	$8,000	$2,800*	$5,200

* Does not apply to Medicare-primary enrollees.

Single Visit Copayment

Effective July 1, 2024, only a single $25 copayment will be charged for all covered services rendered under the Medical/Surgical Program (office visit, office surgery, radiology, diagnostic test or laboratory service) by a participating provider in a single visit. **Note:** Copayment amounts are not changing, so your existing copayment card is still valid. Contact your Health Benefits Administrator if you need a replacement copayment card.

Visit Limit for Medical Massage Therapy

Medical massage therapy will continue to be covered under the Basic Medical Program, subject to the annual deductible and 20 percent coinsurance. **Effective July 1, 2024**, there will be a maximum of 20 visits per calendar year allowed under the Plan. Visits to a network Managed Physical Medicine Provider do not generally count toward the 20-visit limit. In addition, any medical massage therapy services rendered prior to July 1, 2024, do not count toward the new maximum.

Visit Limit for Acupuncture Services

Acupuncture services with a participating provider are subject to a single copayment with no annual visit limit and this benefit is not changing. If you choose to receive acupuncture services from a nonparticipating provider, you will be subject to a maximum of 20 visits per calendar year beginning July 1, 2024 and the deductible and 20 percent coinsurance will apply. Visits prior to July 1, 2024, do not count toward the new maximum.

New Center of Excellence for Substance Use Disorder

Since the start of the COVID-19 pandemic, researchers have observed a dramatic increase in substance use in the United States as a way of coping with social isolation, stress and decreased access to treatment. In an effort to increase access to care and provide enrollees and their families with the support they need, The Empire Plan has developed a new Center of Excellence (COE) for Substance Use Disorder in partnership with the nationally recognized Hazelden Betty Ford (HBF) Foundation, trusted experts in treating addiction.

Effective July 1, 2024, the COE will offer paid-in-full, high-quality treatment services to you and your covered dependents at HBF Foundation locations throughout the United States, including detox facilities located in California, Minnesota and Oregon and outpatient services in California, Florida, Illinois, Minnesota, New York, Oregon and Washington. Participation in a COE program is voluntary and if the Mental Health and Substance Use (MHSU) Program authorizes benefits, the following services are available:

- Assessment prior to treatment
- Full evaluation at the provider site
- Intensive outpatient treatment and partial hospitalization
- Detox 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 virtual support services

When applicable, a travel, lodging and meal allowance is available. The travel allowance will include coverage for up to two companions, regardless of the patient's age.

Note: The program is only available for Empire Plan-primary enrollees; Medicare-primary members are not eligible.

If you have questions regarding the new COE Program, call The Empire Plan and choose the MHSU Program (see *Contact Information*, page 10).

Covered-in-Full Benefit for Mastectomy Bras

Effective July 1, 2024, mastectomy bras obtained from a nonparticipating provider will no longer be subject to deductible or coinsurance. This means that you or your covered dependent will have a paid-in-full benefit regardless of whether the provider participates with The Empire Plan.

No Copayment for Virtual Visits Using LiveHealth Online

Remote health care visits using LiveHealth Online (LHO) are a cost-effective and convenient alternative to urgent care centers, emergency rooms and in-person office visits. Through LHO, you can access a board-certified doctor, psychiatrist, psychologist or licensed therapist for a telephone or video visit on your smartphone, tablet or personal computer at no cost to you. **Effective July 1, 2024**, this will be a permanent Empire Plan benefit.
To register, go to the Hospital Program website (www.anthembluecross.com/nys) and select the link to LiveHealth Online. Enter your Empire ID Card number and select Anthem from the list of insurers when prompted. If you need assistance, call LHO at 1-888-LiveHealth (1-888-548-3432), 24 hours a day, seven days a week. A reminder that telehealth visits with a participating provider outside of LHO are subject to the same copayment as in-person visits.

New Reimbursement Methodology for Non-Network Claims

The Empire Plan's benefit design allows enrollees and covered dependents to use out-of-network providers for services under the Medical/Surgical Program (through the Basic Medical Program) and the Mental Health and Substance Use (MHSU) Program. **Effective July 1, 2024**, the allowed amount for reimbursement of non-network claims will be based on 275 percent of the Medicare rates published by the Centers for Medicare & Medicaid Services (CMS), instead of the current methodology of 90th percentile of FAIR Health® rates. This means that when you choose a nonparticipating provider, you will be reimbursed at rates based upon those that Medicare pays. Since out-of-network providers can balance bill you for their full charges, this could result in higher out-of-pocket costs. Consider using a participating provider to avoid large out-of-pocket costs.

Please refer to the following questions and answers for additional information about this change.

Q: What types of services are affected by this change?

A: Services impacted are non-emergency services from an out-of-network provider such as a scheduled office visit or surgical procedure under the Medical/Surgical Program or outpatient services under the MHSU Program. For example, an appointment you scheduled with a provider who is not in The Empire Plan network.

Q: What does this change mean to me if I always see providers who are in The Empire Plan network?

A: This change does not impact you. In fact, Empire Plan benefits are improving on July 1, 2024, so only one $25 copayment is charged during a single office visit when using a network provider. Previously, up to two copayments could be charged during an office visit when there were laboratory tests or diagnostic services performed, such as an X-ray or electrocardiogram (EKG).

Q: How can I make sure that a provider is in The Empire Plan network?

A: You can check the online directory on NYSHIP Online and select the link to the appropriate online directory (Medical/Surgical Program or MHSU Program) or call The Empire Plan and select the appropriate Program (see *Contact Information*, page 10).

For mental health or substance use disorder providers, press or say 3 and choose the prompt for the Clinical Referral Line (CRL). Under the MHSU Program, you have guaranteed access to network benefits if you use the CRL to help you arrange care with an appropriate provider and they are unable to find you an in-network provider.

Q: What does this change mean to me if I choose to see an out-of-network provider?

A: You may have higher out-of-pocket costs. The Empire Plan uses 275 percent of Medicare rates published by the Centers for Medicare & Medicaid Services (CMS) as the amount allowed on out-of-network claims. This may increase the amount you owe for out-of-network claims. While you are responsible for a deductible and coinsurance when using out-of-network providers ($1,250 deductible and $3,750 coinsurance for most enrollees*), your provider may bill you their full charges beyond your deductible and coinsurance (balance billing).

Q: What does it mean that a provider can balance bill me for services?

A: An out-of-network provider can bill you for the difference between their billed amount and the amount allowed by The Empire Plan. **Note:** When using a **network** provider or facility, you have additional protections against balance billing and surprise bills. You have no protections against balance billing when you choose to receive non-emergency services from an out-of-network provider and this could result in larger out-of-pocket costs for you.

Q: How will I know if the provider will balance bill me for a visit or service?

A: For non-emergency services, it is your responsibility to know whether a provider you choose is in The Empire Plan network. If the provider is not in the network, you may ask the provider to disclose their fees. Keep in mind that a separate deductible and coinsurance apply for any out-of-network services that you, your spouse/domestic partner or your dependents receive.

* $625/$1,875 for employees in a Salary Grade 6 or below

Q: I need a specialist and there are not any network providers in my area. What should I do?

A: You should call The Empire Plan (see *Contact Information*, page 10). For medical/surgical providers, press or say 1 and for mental health or substance use disorder providers, press or say 3 and choose the prompt for the Clinical Referral Line (CRL). The Empire Plan can assist you in obtaining network benefits from a medical/surgical provider if there is not a network provider within 30 miles or 30 minutes from your home address. Under the MHSU Program, if there are no network providers in your area, you have guaranteed access to network benefits if you use the CRL to help you arrange care with an appropriate provider.

Q: What is an example of costs when using an out-of-network provider instead of a network provider?

A: Mary, an Empire Plan member, chooses to see an Empire Plan provider about her ear pain. By choosing a network provider, the only out-of-pocket expense that Mary will have to pay is her $25 participating provider copayment.

Bob, Mary's spouse, has joint pain in his knee. Bob decides to seek care from an out-of-network provider. This provider charges Bob $380 for an office visit and requires that Bob pay the full cost up front. Following the visit, Bob submits a claim for $380. Under the Basic Medical Program, The Empire Plan will allow $300 based on the Medicare published rates. Since Bob already met his deductible, The Empire Plan will cover 80 percent of the $300, or $240. The other $140 are Bob's out-of-pocket expenses ($80 balance billing amount plus $60 coinsurance). If Bob had chosen an Empire Plan network provider, his only out-of-pocket expense would have been a $25 copayment.

Q: If I choose to see an out-of-network provider, can I find out in advance what my out-of-pocket costs might be?

A: Yes, you can request a predetermination of benefits from The Empire Plan to help determine what your actual costs will be. For Medical/Surgical Program services, your provider will need to complete the *Empire Plan Predetermination Form* on your behalf. Once complete, either you or your provider can mail it to the address listed on the form.

Although there is no predetermination of benefits service under the MHSU Program, remember that precertification is required for the following outpatient services, regardless of whether the provider is in The Empire Plan network:

- Intensive outpatient program for mental health
- Structured outpatient program for substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavioral Analysis (ABA)

If you need additional assistance with requesting a predetermination of benefits or precertification of benefits, you can call The Empire Plan and select the prompt for the appropriate Program (see *Contact Information*, page 10).

Q: Can I appeal a bill from an out-of-network provider?

A: No, unless you believe the services should be considered under surprise billing rules. Surprise billing protections generally apply for emergency services, when you utilize a network facility or for specific circumstances, such as a provider sending a specimen to a non-network laboratory without your consent. **To best protect yourself from large, unexpected bills, you should choose a network provider or facility.**

Q: Does this change have any impact on when a bill from a non-network provider is considered a surprise bill?

A: No, this change does not impact surprise billing rules. These rules provide you with protections if you did not choose to receive care from an out-of-network provider. Your Explanation of Benefits (EOB) will provide you with information on who to contact if you believe you have received a surprise bill.

As a reminder, the MHSU Clinical Referral Line is available 24 hours a day, 7 days a week and can help you find mental health and substance use disorder providers. The Empire Plan NurseLine℠ is also available 24/7 and registered nurses can help you find network medical providers or assist you with questions about a medical concern or condition.

Reminders

Annual Notice of Mastectomy and Reconstructive Surgery Benefits

The Empire Plan covers inpatient hospital care for lymph node dissection, lumpectomy and mastectomy for treatment of breast cancer for as long as the physician and patient determine hospitalization is medically necessary. The Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery on the other breast to produce a symmetrical appearance. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute.

Call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 10) if you have questions about your coverage for implants, breast forms or other prostheses related to breast cancer treatment.

Empire Plan Benefits Management Program requirements apply. See your *Empire Plan Certificate* for more information.

Keep Your Enrollment Record Up to Date

It is important for you to keep us up to date with changes in your life to ensure you receive timely and appropriate information about your health insurance coverage. Your coverage through NYSHIP is a valuable benefit, but it is also costly to provide. By keeping your information up to date and only covering dependents who are eligible, you help to keep costs down for both yourself and the Program.

Inform your Health Benefits Administrator (HBA) in writing of any changes to your enrollment record (address, adding or removing dependents, marital status changes) in a timely manner. **Note:** If you are divorced or your marriage has been annulled, your former spouse is not eligible for coverage as a dependent as of the date of the divorce, even if a court orders you to maintain coverage.

Your HBA is usually located in your personnel office or the New York State Business Services Center. You may also make certain changes, such as your address, by going to MyNYSHIP — Enrollee Self-Service at www.cs.ny.gov/mynyship, a secure portion of NYSHIP Online. See your NYSHIP *General Information Book* for more information on enrollment changes and applicable deadlines.

Ineligible Dependents

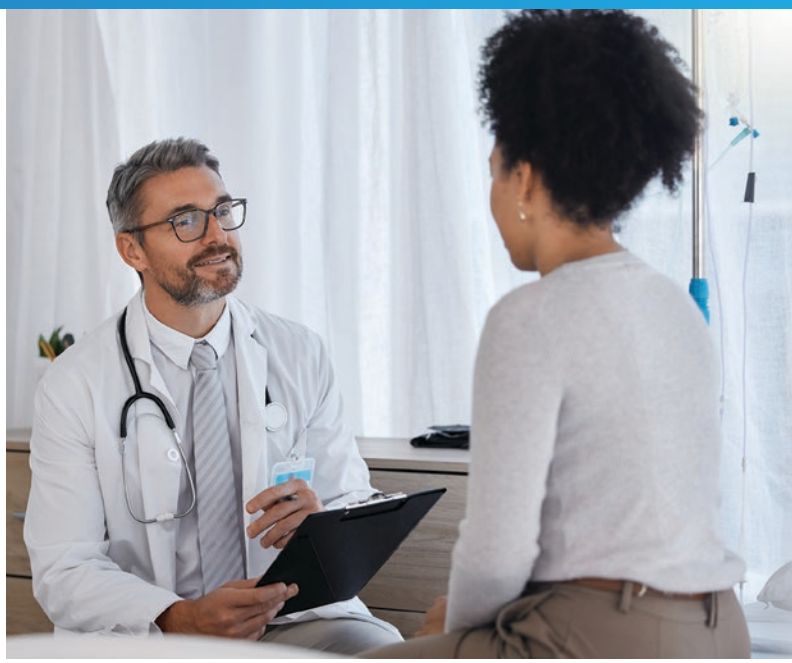
If you fail to inform your HBA of dependent eligibility changes, you may be responsible for repaying all health insurance claims for ineligible dependents as early as the date they became ineligible. Knowingly withholding information regarding the ineligibility of dependents may constitute fraud and may be turned over to the appropriate enforcement agencies for investigation.

Annual Notice of Colorectal Cancer Screening Benefit

In accordance with the U.S. Preventive Services Task Force (USPSTF), The Empire Plan covers preventive colorectal cancer screenings and laboratory tests for enrollees age 45 through 75 when performed by a participating provider. 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 also includes pre-procedure consultation and any resulting pathology exam or polyp biopsy. While a copayment would not apply for the initial preventive procedure(s), additional screenings provided in accordance with the American Cancer Society (ACS) guidelines may be considered diagnostic and a copayment would apply. For more information on ACS guidelines, go to www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html.

If you have questions about your coverage for preventive colorectal cancer screenings and follow-up diagnostic care, call The Empire Plan and choose the Medical/Surgical Program (see *Contact Information*, page 10).

Empire Plan Benefits Management Program requirements apply. See your *Empire Plan Certificate* for more information.



Empire Plan Certificate and *Amendments*

The Empire Plan *Certificate* and *Amendments* provide an in-depth description of benefits provided through The Empire Plan. Both your *Certificate* and *Amendments* will be updated shortly with benefits effective December 31, 2023, and will be available online; printed copies are not available.

Note: A new *Certificate*, containing all Empire Plan benefit changes effective July 1, 2024, will be mailed to your home when complete.

For the most updated version of your *Certificate* and *Amendments*, go to NYSHIP Online (see *Contact Information*, page 10). From the homepage, select Using Your Benefits and then Current Publications.

Contact Information

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

PRESS OR SAY 1	**Medical/Surgical Program: *Administered by UnitedHealthcare*** Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time. TTY: 1-888-697-9054 P.O. Box 1600, Kingston, NY 12402-1600 Claims submission fax: 845-336-7716 Online: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Anthem Blue Cross*** Administrative services are provided by Anthem HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Representatives are available Monday through Friday, 8 a.m. to 5 p.m., Eastern time. TTY: 711 New York State Service Center, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 Claims submission fax: 866-829-2395 Online: www.anthembluecross.com/nys/resources-forms
PRESS OR SAY 3	**Mental Health and Substance Use Program: *Administered by Carelon Behavioral Health, Inc.*** Representatives are available 24 hours a day, seven days a week. TTY: 1-855-643-1476 P.O. Box 1850, Hicksville, NY 11802 Claims submission fax: 855-378-8309 Online: www.achievesolutions.net/empireplan
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS Caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 711 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590 Claims submission: P.O. Box 52136, Phoenix, AZ 85072-2136
PRESS OR SAY 5	**Empire Plan NurseLine℠: *Administered by UnitedHealthcare*** Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.

Benefits on the Web

To learn more about your benefits, including finding Empire Plan providers and updated NYSHIP publications, go to NYSHIP Online at www.cs.ny.gov/employee-benefits. Select New York State Active Employee (NY) and then your group and Empire Plan Enrollee, if prompted, to access the NYSHIP Online homepage.

The *Empire Plan Special Report* is published by the Employee Benefits Division of the New York State Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits through The Empire Plan.

NEW YORK STATE | NYSHIP New York State Health Insurance Program

New York State Department of Civil Service
Employee Benefits Division, Albany, New York 12239
518-457-5754 or 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
www.cs.ny.gov

When You Must Call The Empire Plan 1-877-7-NYSHIP (1-877-769-7447)

The Empire Plan Hospital Benefits Program *Anthem Blue Cross,* www.anthembluecross.com/nys
Call for information regarding hospital and related services.

YOU MUST CALL AND PRESS OR SAY 2
Benefits Management Program for Preadmission Certification – You must call before a scheduled hospital admission, within 48 hours (or as soon as reasonably possible) after an emergency or urgent hospital admission and before admission or transfer to a skilled nursing facility (includes rehabilitation facilities). Preadmission certification is not required for maternity admissions, however, you must call when admitted due to complications related to your pregnancy or for any reason other than the delivery of your baby.

YOU MUST CALL AND PRESS OR SAY 2
Center of Excellence for Transplants Program – You must call before a hospital admission for the following transplant surgeries: bone marrow, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell and simultaneous kidney/pancreas. This requirement applies whether or not you choose to participate in the Center of Excellence for Transplants Program.

The Empire Plan Medical/Surgical Benefits Program *UnitedHealthcare,* www.myuhc.com
Call for information on benefits under Participating Provider, Basic Medical Provider Discount and Basic Medical Programs, predetermination of benefits, claims and participating providers.

Managed Physical Medicine Program – Call for information on benefits and to find network providers for chiropractic treatment, physical therapy and occupational therapy. If you do not use network providers, you will receive a significantly lower level of benefits.

YOU MUST CALL AND PRESS OR SAY 1
Benefits Management Program for Prospective Procedure Review of MRIs, MRAs, CT Scans, PET Scans and Nuclear Medicine Tests – You must call before having an elective (scheduled) procedure or nuclear medicine test.

YOU MUST CALL AND PRESS OR SAY 1
Home Care Advocacy Program (HCAP) – You must call to arrange for paid-in-full home care services, enteral formulas, diabetic shoes, insulin pumps and/or durable medical equipment/supplies. If you do not follow HCAP requirements, you will receive a significantly lower level of benefits. You must also call for HCAP approval of an external mastectomy prosthesis costing $1,000 or more.

YOU MUST CALL AND PRESS OR SAY 1
Center of Excellence for Cancer Program – You must call to participate in The Empire Plan Center of Excellence for Cancer Program.

The Empire Plan Mental Health and Substance Use Program *Carelon Behavioral Health, Inc.,* www.achievesolutions.net/empireplan

To ensure the highest level of benefits, call before seeking services from a covered mental health or substance use provider, including treatment for alcoholism. Some services require precertification to confirm medical necessity before starting treatment. For a list of those services, call The Empire Plan and press or say 3. From there you can reach the Clinical Referral Line to find out more information about precertification.

YOU MUST CALL AND PRESS OR SAY 3
Center of Excellence for Substance Use Disorder Program – You must call to participate in The Empire Plan Center of Excellence for Substance Use Disorder.

The Empire Plan Prescription Drug Program *CVS Caremark*, www.caremark.com
For the most current list of prior authorization drugs, call the Program or go to NYSHIP Online (see *Benefits on the Web*, page 10). From the homepage, select Using Your Benefits, Empire Plan Formulary Drug Lists and then Prior Authorization Drug List.

New York State
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
www.cs.ny.gov

Please do not send mail or correspondence to the return address. See address information on page 10.

SAVE THIS DOCUMENT

NEW YORK STATE | **NYSHIP**
New York State Health Insurance Program

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

NY Active (DC-37/NYSCOPBA)
Empire Plan Special Report – May 2024

NY Active (DC-37/NYSCOPBA) Empire Plan Special Report - 5/24 NY1520

Infusion Therapy Site of Care Program

Alternate site-of-care infusion therapy options have been proven to provide many patients with a safe and convenient alternative to infusion therapy in an outpatient hospital setting. Treatment at home, in your doctor's office or in a freestanding infusion suite is often preferable to infusions in an outpatient hospital setting because it is more convenient and allows many patients to return to their normal activities sooner.

Effective July 1, 2024, Empire Plan-primary enrollees and dependents will be eligible to participate in The Empire Plan's new Site of Care Program for all drug infusion therapies except those used to treat cancer or hemophilia. Under the new program, infusions that can be safely administered outside of a hospital setting will be transitioned to a freestanding infusion suite, your doctor's office or your home. When infusion therapy is reviewed by the program for medical necessity, the setting will also be reviewed to ensure it's being done in the most appropriate location. Patients who are currently receiving infusion therapy will receive a letter from the program to help transition them to an alternate setting.

Talk to your doctor to determine whether an alternate site of care is clinically appropriate for you or your dependent's infusion. The Empire Plan will help you find alternate settings and offer options to both you and your doctor. The medical or prescription drug copayments associated with infusions will be waived when you choose a non-hospital infusion site of care, just as they are now in an outpatient hospital setting.

If you have questions about the Site of Care Program for Infusions, talk to your doctor or call The Empire Plan and choose the Hospital Program (see *Contact Information*, page 10).