JANUARY 1, 2025

EMPIRE PLAN CERTIFICATE AMENDMENTS

NEW YORK STATE HEALTH INSURANCE PROGRAM

PARTICIPATING EMPLOYERS

For active employees, retirees, vestees
and dependent survivors enrolled
through Participating Employers (PEs),
their covered dependents,
COBRA enrollees and
Young Adult Option enrollees.

This document describes
benefit changes effective January 1, 2024,
through January 1, 2025.

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* ***January 1, 2025****.*

Empire Plan Certificate of Insurance

Combined Out-of-Pocket Limits

Add the following as the last sentence of the paragraph:

Limits are determined annually by negotiated benefit changes.

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 $4,120 for Individual coverage and $8,240 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Use and Prescription Drug Programs as follows:

Individual coverage

- $2,670 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
- $1,450 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)

Family coverage

- $5,350 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use Programs
  - The $2,670 Individual coverage limit applies to each Plan enrollee/dependent with Family coverage; the maximum amount of $5,350 applies for all enrollees combined
- $2,890 for in-network expenses incurred under the Prescription Drug Program (does not apply to Medicare-primary enrollees or dependents)
  - The $1,450 Individual coverage limit applies to each Plan enrollee/dependent with Family coverage; the maximum amount of $2,890 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.

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 67.

Outpatient Hospital Care

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.

Site of Care for Infusions Program

Replace the first sentence with the following:

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 outpatient hospital setting is clinically appropriate for Your infusions.

Delete the fifth sentence:

Effective July 1, 2023, the Site of Care Program expanded to include all drug infusion therapies except those used to treat cancer or hemophilia.

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.

Definitions

Add the following and re-letter the list:

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).

Participating Provider Program

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

Add the following as the second sentence of the second paragraph:

See *Urgent Care Center*, page 59, for more information about Urgent Care coverage under the Participating Provider Program, including Copayments.

Combined out-of-pocket limit

Add the following as the last sentence of the paragraph:

Limits are determined annually by negotiated benefit changes.

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:

- $2,670 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs

Family coverage:

- $5,350 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Use (MHSU) Programs
  - The $2,670 Individual coverage limit applies for each Plan enrollee/dependent with Family coverage; the maximum amount of $5,350 applies for all enrollees combined

What is covered under the Participating Provider Program

Add the following bullet after the last paragraph in 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.

Add the following and re-letter the list:

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.

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 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 84).

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

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.

How to estimate Nonparticipating Provider costs

Replace the second and third paragraphs with the following:

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:

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.

Replace the first two sentences of re-lettered item T. **Medical Massage Therapy** *with the following:*

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.

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 the last sentence of the first paragraph of re-lettered item AL. **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 84).

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 73).

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.

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 62. If You disagree with the Plan's determination, You may follow the Appeal process (see *Appeals*, page 99), 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.

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

Replace the **Note** *in 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 item D. **Autism Spectrum Disorder** *with the following:*

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

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

Replace the first bullet of 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.

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