



GENERAL INFORMATION & BOOK EMPIRE PLAN CERTIFICATE AMENDMENTS

For Employees of the State of New York
designated by **Management/Confidential; Legislature**
and for their enrolled dependents
and for COBRA enrollees with their benefits

JUNE 2002

State of New York Department of Civil Service
Employee Benefits Division
www.cs.state.ny.us

**Keep these amendments with
your January 1, 2002 New York
State Health Insurance Program
General Information Book and
Empire Plan Certificate.**

Pages in your Book/Certificate and
later Certificate Amendments have
consecutive numbers.

New York State Health Insurance Program General Information Book

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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 non-represented 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.

Where this document differs from your January 1, 2002 *NYSHIP General Information Book and Empire Plan Certificate*, this is the controlling document.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

Substitute the following for “5. Disabled dependents” in the “Who is Eligible?” section on page 7 of your NYSHIP General Information Book.

Disabled dependents

5. Your unmarried dependent children age 19 or over who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for health insurance are eligible. For example, if your child becomes disabled at age 19 or older while covered as a full-time dependent student, the child may qualify to continue coverage as a disabled dependent.

If you have a child who is enrolled in NYSHIP and qualifies for coverage as a disabled dependent, you must provide medical documentation. If you anticipate eligibility on this basis, you must file a Disability Form PS-451. Contact your agency Health Benefits Administrator as soon as possible after enrollment, even if your child is under the age when eligibility would normally terminate through age disqualification.

However, if your disabled dependent child was not enrolled in NYSHIP because the child had other health insurance, and loses the other coverage involuntarily, you may apply for disabled dependent child coverage. For your application to be considered, you must file a Disability Form PS-451 as soon as possible. You must provide proof that the disability occurred prior to NYSHIP’s standard age disqualification date and the loss of other coverage was involuntary.

If your child who is age 19 or over but under age 25 is covered as a full-time student, and is disabled or becomes disabled while a full-time student, contact your agency Health Benefits Administrator as soon as possible to file Disability Form PS-451.

Substitute the following for the last bulleted item under “Changes permitted only after certain events” in the “Costs, Pre-Tax Program...” section on page 14 of your NYSHIP General Information Book.

Pre-tax deduction

- There is a significant change in your or your spouse’s health coverage which is attributable to your or your spouse’s employment.

Substitute the following for the first paragraph under “Empire Blue Cross and Blue Shield conversion” in the “Changing from NYSHIP to a Direct-Pay Conversion Contract” on page 31 of your NYSHIP General Information Book.

Conversion contract

Conversion policies are available from Empire Blue Cross and Blue Shield. A direct-payment hospital coverage only contract is available to all enrollees. A direct-payment HMO or HMO/POS contract is available to enrollees residing in Empire Blue Cross and Blue Shield’s 28 county service area. If you live outside the 28 county service area, Empire Blue Cross and Blue Shield can direct you to a local Blue Cross and/or Blue Shield plan that can provide you with information on a direct-payment HMO or HMO/POS

contract. There is no conversion right for enrollees who have existing coverage that would duplicate the conversion coverage.

However, there are limits if you are eligible for Medicare.

EMPIRE BLUE CROSS AND BLUE SHIELD CERTIFICATE OF INSURANCE

Substitute the following for “2. Termination of this Plan.” in the “Termination of Your Empire Blue Cross and Blue Shield Coverage” section on page 65 of your Empire Blue Cross and Blue Shield Certificate.

Termination of coverage

2. **Termination of this Plan.** If this Plan ends, your coverage will end.

Insert the following as the second paragraph of the “Right to New Contract After Termination” section on page 65 of your Empire Blue Cross and Blue Shield Certificate.

Conversion contract

You may apply to Empire Blue Cross and Blue Shield for a direct-payment contract. A direct-payment hospital only contract is available to all enrollees. A direct-payment HMO or HMO/POS contract is available to enrollees residing in Empire Blue Cross and Blue Shield's 28 county service area. If you live outside the 28 county service area, Empire Blue Cross and Blue Shield can direct you to a local Blue Cross and/or Blue Shield plan that can provide you with information on a direct-payment HMO or HMO/POS contract. There is no conversion right for enrollees who have existing coverage that would duplicate the conversion coverage.

Substitute the following for “2. The new contract.” in the “Right to New Contract After Termination” section on page 65 of your Empire Blue Cross and Blue Shield certificate.

2. **The new contract.** The direct-payment hospital only contract will be a contract that meets, at a minimum, New York State's requirements for basic hospital insurance. It will not provide benefits identical to the Empire Plan. The HMO or HMO/POS contract will be the standardized contract required to be sold on a direct-payment basis.

UNITED HEALTHCARE CERTIFICATE OF INSURANCE

Substitute the following for the third paragraph of “A. Office and Home Visits” under “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 78 of your United HealthCare Certificate.

Allergy immunotherapy

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.

Substitute the following for “D. Specialist Consultations” under “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 79 of your United HealthCare Certificate.

Specialist consultations

D. **Specialist Consultations** – Your doctor may refer you to a specialist for a consultation. During the consultation, the specialist will evaluate your medical condition and give you and your doctor professional advice on how to proceed with your care.

You are covered, subject to a \$10 copayment, for one **out-of-hospital** consultation in each specialty field per calendar year for each condition being treated. You are covered for one **in-hospital** consultation in each specialty field, per confinement, for each condition being treated.

You are **not** covered for consultations in the fields of pathology, roentgenology or anesthesiology. Exception: Consultations by an

anesthesiologist, not rendered in conjunction with anesthesia services for surgery, such as office consultations for pain management, are covered when medically necessary.

Insert the following after “D. Specialist Consultations” under “What is covered under the Participating Provider Program” in the “Participating Provider Program” section on page 79 of your United HealthCare Certificate. (Adjust the letters that follow.)

Cancer diagnosis

- E. **Second Opinion for Cancer Diagnosis** – You pay a \$10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

Substitute the following for “J. Ambulance Service” under “What is covered under the Basic Medical Program (non-participating providers)” in the “Basic Medical Program” section on page 82 of your United HealthCare Certificate.

Emergency ambulance service

- J. **Emergency Ambulance Service** — Ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and ambulance transportation is required because of an emergency condition. Covered medical expenses for ambulance service are:
- Local commercial ambulance charges except for the first \$35. *These amounts are not subject to deductible or coinsurance.*
 - When the enrollee has no obligation to pay for the use of an organized voluntary ambulance service, donations up to a maximum of \$50 for services under 50 miles, \$75 for 50 miles or over. *These amounts are not subject to deductible or coinsurance.*

Add the following at the end of “What is covered under the Basic Medical Program (non-participating providers)” in the “Basic Medical Program” section on page 83 of your United HealthCare Certificate.

Specialist consultations

- V. **Specialist Consultations** – Charges for a visit to a non-participating specialist for a consultation are considered under the Basic Medical Program and are subject to your annual deductible and coinsurance. Basic Medical benefits are available for one **out-of-hospital** consultation in each specialty field per calendar year for each condition being treated. Basic Medical benefits are available for one **in-hospital** consultation in each specialty field, per confinement, for each condition being treated. You are **not** covered for consultations in the fields of pathology, roentgenology or anesthesiology. Exception: Consultations by an anesthesiologist, not rendered in conjunction with anesthesia services for surgery, such as office consultations for pain management, are covered when medically necessary.

Cancer diagnosis

- W. **Second Opinion for Cancer Diagnosis** – Charges for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer are covered in full, minus the \$10 copayment you would normally pay for a visit to a participating provider. *This benefit is not subject to deductible.*

Substitute the following for “Call anytime” and for the first paragraph under “More about HCAP” in the “Home Care Advocacy Program” section on page 87 of your United HealthCare Certificate.

HCAP

Call anytime

Call anytime. When your doctor prescribes home care services, durable medical equipment and certain supplies, call HCAP at 1-800-638-9918 before you receive services.

To talk to a coordinator, call Monday through Friday between 8 am and 4:30 pm, Eastern time. HCAP voice mail is available 24 hours a day.

In an emergency or urgent situation, obtain necessary care. Then, you are advised to call HCAP within 48 hours after receiving emergency care or receiving durable medical equipment/supplies. If it is not reasonably possible to call within 48 hours, call HCAP as soon as possible. If HCAP determines that the urgent or emergency care was medically necessary, covered services and/or items will be certified.

Remember, call 1-800-638-9918 before you receive home care services and/or durable medical equipment or supplies. **And call if you have any questions.**

More about HCAP

If you are admitted to the hospital – If you are receiving home care and then are admitted to the hospital, you must call the Benefits Management Program at 518-367-0009 (Albany area and Alaska) or 1-800-342-9815 (NYS and other states except Alaska) before your hospital admission and within 48 hours after an emergency or an urgent hospital admission.

GHI CERTIFICATE OF INSURANCE

Substitute the following for “Emergency services” in the “How to Receive Benefits for Mental Health and Substance Abuse Care” section on pages 111-112 of your GHI Certificate.

Emergency services

In an emergency, ValueOptions will either arrange for an appropriate provider to call you back right away (usually within 30 minutes), or direct you to an appropriate facility for treatment. In a life-threatening emergency situation, you should go or be taken to the nearest hospital emergency room for treatment. Emergency care provided in an emergency room will be paid in full. If you are admitted to a facility for emergency care, you must call ValueOptions within 48 hours for certification.

When you receive medically necessary covered services from a non-network provider in a certified emergency, the Program will provide network coverage until you can be transferred to a network facility.