NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Manual for NYSHIP Participating Agencies

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Governor

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Maintenance of the Manual

This manual outlines the official procedures for the administration of the New York State Health Insurance Program (NYSHIP) for enrollees of Participating Agencies. Information concerning the benefits provided under the program will be found in the NYSHIP General Information Book and Empire Plan Certificate for Active and Retired Employees of Participating Agencies.

Issuance of Manual Material: All material for this manual will be issued by the Employee Benefits Division of the New York State Department of Civil Service. No changes in, or additions to, this manual will have any authority unless they have been so issued.

Revisions to the Manual: New and revised manual material will be sent by the Employee Benefits Division to Participating Agencies with a transmittal memorandum that describes the items transmitted and the items superseded. The new material should be interfiled in the appropriate sections of the manual, and the Table of Contents noted accordingly. The superseded material should be removed and destroyed. The most recent transmittal memorandum should be filed in the front of the manual and removed when a later memorandum is so filed. The issue date of new and revised material will be noted at the bottom of each page.

Suggested changes to the manual may be submitted to the Employee Benefits Division, New York State Department of Civil Service, Albany, New York 12239.

Policy Memorandums: When necessary, policy directives are issued by the Director of the Employee Benefits Division to provide guidelines on specific issues.

Online access: An up-to-date version of this manual, as well as many other NYSHIP materials, can be accessed online at www.cs.state.ny.us. To access certain materials such as Policy Memos, the Health Benefits Administrator must register and receive an online passcode.

Summary of NYSHIP

The New York State Health Insurance Program (NYSHIP) for Participating Agencies provides the following coverage through the Empire Plan, an indemnity insurance plan with managed care features.

1. Hospitalization Coverage

2. Participating Provider Network and Basic Medical Coverage

3. Mental Health and Substance Abuse Coverage

4. Prescription Drug Coverage

The NYSHIP General Information Book and Empire Plan Certificates of Insurance describe the benefits in detail.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act ("HIPAA") was enacted in 1996 to improve the efficiency and effectiveness of the nation's health care system. The *Standards for Privacy for Individually Identifiable Health Information* ("Privacy Rule") established a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement HIPAA.

In general, the HIPAA privacy regulations:

1. Give individuals the right to access their medical records;

2. Limit the use and disclosure of individually identifiable health information;

3. Restrict most disclosures of information to the minimum needed for the intended purpose; and

4. Provide civil and criminal penalties if these privacy rights are violated.

Enrollees may request a copy of NYSHIP's Notice of Privacy Practice by contacting the Employee Benefits Division or by accessing the website at: www.cs.state.ny.us

Protected Health Information (PHI):

HIPAA covers Protected Health Information (PHI) which is individually identifiable health information relating to:

1. Past, present, or future physical or mental health or condition of an individual;

2. Provision of health care to an individual; or

3. The past, present, or future payment for health care provided to an individual.

Please note that the following information relates to Participating Agencies in NYSHIP only. If the Participating Agency offers other health insurance plans to employees, the Agency should consult with legal counsel regarding how the provisions of HIPAA affect the Agency in relation to those plans. Also, this information pertains only to HIPAA privacy regulations.

Participating Agencies and HIPAA:

As a result of the Employee Benefits Division's review of the HIPAA privacy regulations it has been determined that, within the context of NYSHIP participation, a Participating Agency is subject to some HIPAA privacy requirements. HIPAA has the effect of restricting the flow of certain types of information related to the health care of the employer's employees and restricts the circumstances under which those types of information can be disclosed to the employer by the Plan and the Plan's insurers.

NYSHIP and the Empire Plan insurers may disclose to a Participating Agency information on whether an employee is enrolled in, or has disenrolled from, the Empire Plan. Additionally,

NYSHIP and the Empire Plan insurers may disclose summary health information to a Participating Agency if the Agency requests the summary health information for one of the following purposes:

1. To obtain premium bids from other plans;

2. To provide health insurance coverage under the Participating Agency's group health plan; or

3. To modify, amend or terminate the Participating Agency's group health plan.

NYSHIP provides Participating Agencies with enrollment information and summary health information upon request, and will continue to do so as long as the information, for the purposes described above, is consistent with HIPAA privacy requirements. NYSHIP does not disclose individual-specific health information to Participating Agencies in the absence of a signed authorization by the individual, and will continue to follow that practice, consistent with HIPAA privacy requirements. Therefore, if an employee requests assistance from agency staff in resolving a NYSHIP claims problem that involves the disclosure of protected health information, such authorization will be required.

HIPAA Compliance:

Since a NYSHIP Participating Agency may receive and use only enrollment information and summary health information, NYSHIP Participating Agencies are not subject to most HIPAA privacy implementation requirements. However, the Participating Agency is subject to the following HIPAA privacy requirements:

1. A Participating Agency may not intimidate, discriminate against, or take other retaliatory action against an individual as a consequence of the individual having exercised any right he or she may have pursuant to HIPAA, or as a consequence of an individual having participated in any process established by the HIPAA regulations.

2. A Participating Agency may not require any individual to waive their right to file a complaint with the Secretary of Health and Human Services concerning a potential violation of HIPAA privacy requirements.

Requirements for Agency Participation

NYSHIP is established under Article XI of the NYS Civil Service Law for the purpose of providing health insurance benefits to State employees and retirees and their eligible dependents. The law also allows for inclusion of the employees and retirees of public authorities, public benefit corporations, school districts, special districts, district corporations, and municipal corporations, excluding cities having a population of one million or more. Local government entities that elect to participate in NYSHIP are known as "Participating Agencies."

Participating Agencies must comply with all laws, regulations and policies. Requirements for participation in NYSHIP include:

Election to participate: The governing body of the agency must adopt a resolution electing participation in NYSHIP. For municipal corporations, if required by law, the resolution must be approved by any other applicable body or officer.

Designation of classes to be included: A Participating Agency must designate which classes of employees/retirees are eligible for inclusion under NYSHIP. A Participating Agency may extend coverage to all its eligible employees, or to a single class of employees, or to several classes of employees or designated bargaining units provided the classifications are reasonable and do not establish an arbitrary or discriminatory distinction among the agency's employees.

Examples of classes and categories:

1. All enrollees, including employees, retirees and dependent survivors
2. All employees of a bargaining unit
3. All non-represented employees
4. All employees of a bargaining unit hired on or after a specific date
5. All retirees
6. All retirees who retire on or after a specific date

Note: A Participating Agency may elect to cover active employees only. However, an agency ***must*** cover active employees to cover retirees.

Minimum participation levels: Before NYSHIP coverage can be effective, a Participating Agency must meet the following minimum participation levels:

a. If an agency elects to extend coverage to a single class of employees, at least 75% of the eligible employees in that class must be enrolled in NYSHIP or an HMO or other employer sponsored plan before coverage can become effective.

b. If an agency elects to extend coverage to two or more classes of employees at the same time, at least 75% of the eligible employees in the combined classes must be enrolled in NYSHIP or an HMO or other employer sponsored plan before coverage can become effective.

c. If a class of employees not covered initially is later offered the opportunity to enroll, at least 75% of the eligible employees of that class must be enrolled in NYSHIP or an HMO or other employer sponsored plan before coverage can become effective.

d. If two or more classes not initially covered are later offered the opportunity to enroll, at least 75% of the eligible employees in the combined classes must be enrolled in NYSHIP or an HMO or other employer sponsored plan before coverage can become effective.

For the purpose of establishing minimum participation levels, prior retirees are considered to be a class.

Minimum contribution level: Participating Agencies are required under NYS Law to pay a minimum employer-share contribution rate of 50% of the cost of Individual coverage and 35% of the cost of Dependent coverage under NYSHIP on behalf of enrolled active employees and retirees. However, such agencies may elect or negotiate to pay any higher rate of contribution up to 100% of the cost of both Individual and Dependent coverage.

A Participating Agency may change contribution rates. An agency must notify the Employee Benefits Division (EBD) of any change in their rate of contribution. Notice of the proposed change should be sent to the Employee Benefits Division at least 90 days in advance of the first month for which the new rate will become effective. In no case may the contribution rate be lower than the statutory minimums.

For certain categories of enrollees, a Participating Agency is **not** required to pay the minimum contribution rate of 50% / 35%. Refer to the appropriate sections in this manual for specific information on the rates of contribution for the following:

1. Enrollees temporarily removed from the payroll (authorized leave of absence)(See Section 3.4);

2. Enrollees in vested status (See Section 3.14);

3. Enrollees who are dependent survivors (See Section 3.10);

4. Enrollees who are covered under either COBRA (See Section 3.12) or NYS Continuation of Coverage (See Section 3.11);

5. Enrollees whose eligibility is based on their being a school board member of a Participating Agency (See Section 2.1);

6. Unpaid Board Members of Public Authorities (See Section 2.1);

7. Unpaid Publicly Elected Board Members (See Section 2.1);

8. Unpaid Local Publicly Elected Officials (See Section 2.1).

Participating Agencies have the flexibility to establish their own policies within certain areas of NYSHIP. The following is a summary of those areas in which discretion is granted:

1. Years of service required for continued benefits after retirement (i.e., can be greater than 5 years as outlined in Section 3.7)

2. Different contribution rates for different classes of enrollees (survivors/retirees included), provided the minimum contribution rate is satisfied for each class. (See Section 1.5)

3. Restriction of vesting coverage to employees within 5 years of retirement eligibility (i.e., a vestee must be within 5 years of retirement to be eligible for vestee coverage)

4. The waiting period for new employees (not exceeding 6 months)

5. Election of Domestic Partner coverage

6. Recognition of prior public service in order to meet the minimum service requirement for eligibility in retirement

7. Allowing or prohibiting two family policies. A Participating Agency may elect to prohibit two family policies if both enrollees work for the same Agency. However, a Participating Agency cannot deny NYSHIP Family coverage to an otherwise eligible employee based on the fact that the employee's spouse is also eligible for NYSHIP coverage through a different employer. (See Policy Memo 133)

8. Frequency of Medicare Part B reimbursement (i.e., monthly, quarterly, or yearly)

9. The duration of NYSHIP coverage for employees who resign or are terminated (See Section 3.9)

Medicare Part B Reimbursement: Regardless of a Participating Agency's rate of contribution, Section 167a of the NYS Civil Service Law requires that the Participating Agency must also reimburse the Medicare Part B premium for each enrollee (i.e., retiree, spouse or other eligible dependent of retiree) who is eligible for Primary benefits under Part B of the Federal Medicare Program whether or not the person has enrolled in Part B of the Medicare Program (see Section 3.8). An enrollee eligible for Primary benefits under Medicare is entitled to this reimbursement since benefits under NYSHIP are reduced to the extent that benefits are available under Medicare.

1. A Participating Agency may **not** reduce its employer rate of contribution for an enrollee due to the fact that he or she or an eligible dependent becomes entitled to Primary benefits under Medicare and thus eligible for the Medicare Reimbursement.

2. Note that a Participating Agency is not required to reimburse the cost of the Medicare Part B premium when NYSHIP is Primary. For example, NYSHIP is Primary for an enrollee who is an active employee even though the person is 65 years of age. When he or she retires, Medicare would then become the Primary insurer.

Rates of Contribution

Participating Agencies are required under NYS Law to pay a minimum employer-share contribution rate of 50% of the cost of Individual coverage and 35% of the cost of Dependent coverage under NYSHIP on behalf of enrolled active employees and retirees. However, such agencies may elect or negotiate to pay any higher rate of contribution up to 100% of the cost of both Individual and Dependent coverage.

A Participating Agency may establish or negotiate different rates of contribution for different categories of employees. However, any such categories must be reasonable classifications which would not constitute an arbitrary or discriminatory distinction.

Permitted differences. Some types of permitted differences in contribution rate are:

1. Different rates of contribution for different bargaining units. For example, different rates for personnel represented by a uniformed services bargaining unit and those represented by an administrative services bargaining unit.

2. Different rates of contribution for enrollees in a particular bargaining unit hired before a specified date and enrollees in the same bargaining unit hired after that date.

3. Different rates of contribution for tenured employees and non-tenured employees.

4. Different rates of contribution for full-time and part-time employees. In these cases, rates may also vary for different categories of full-time and part-time employees.

5. Different rates of contribution for different groups of retirees, based on bargaining units. For example, a Participating Agency could negotiate different rates in retirement for teaching and non-teaching personnel.

6. Different rates of contribution for enrollees who retire from vested status.

7. Different rates of contribution for different groups of retirees based on age at date of retirement, length of service with the employer or both.

   Example: A Participating Agency has a bargaining unit composed of police and firemen who are eligible to retire after 20 years of service regardless of age and another bargaining unit for employees who must meet the minimum age requirement of 55. The agency could negotiate one rate of contribution for those employees who retire at age 55 with at least 10 years of service and a different rate for those police or firemen who chose to retire at a younger age.

Prohibited differences. Prohibited differences in rates of contribution include:

1. Different rates of contribution based on Medicare eligibility; Medicare eligibility is not a permitted distinction in establishing a separate category for rates of contribution.

2. Any difference in rates of contribution using a basis that constitutes an arbitrary or discriminatory distinction.

3. Persons who do not meet the eligibility requirements outlined in Section 2.1 are not eligible to enroll in NYSHIP even by paying the full cost of coverage.

Note: An agency may change rates of contribution; however, any Participating Agency considering a rate structure not listed above must contact the Employee Benefits Division in writing. The Division will inform the agency if the proposed contribution rate structure is permissible.

Health Insurance and Collective Bargaining

The following information is included in this manual to serve as a general guide for agency administrators in their negotiations with employee bargaining units. While not all-inclusive, it does identify those aspects of the New York State Health Insurance Program (NYSHIP) which may not be modified at the local level as well as those which are subject to change through negotiations or administrative action on the part of a Participating Agency.

In the event of a proposal or question which is not addressed in this section, contact the Employee Benefits Division for an opinion. Failure to do so could result in a Participating Agency entering into an agreement which would have no validity under the laws and regulations governing NYSHIP.

Eligibility and Benefits (Section 2.1)

NYSHIP will **not** recognize any variations in the eligibility requirements or benefits of NYSHIP negotiated or established administratively by a Participating Agency which are not within the parameters established in the laws and regulations governing the Program, administrative policies, this manual of procedures, and the Empire Plan booklets.

Contribution Rates (Section 1.5)

Participating Agencies may adopt different contribution rates for different classes of employees or designated bargaining units provided the classes are reasonable classifications and do not establish an arbitrary or discriminatory distinction among the agency's employees, and provided also that the agency's rates of contribution are no less than the statutory minimum of 50% of the cost of Individual coverage and 35% of the cost of Dependent coverage.

Other Areas of Discretion

The Section “Requirements for Agency Participation” found in this Introduction highlights many other areas where Participating Agencies have the flexibility to establish their own policies.

Restrictions

Although this list is <u>not</u> all-inclusive, the following represent important Program rules that cannot be locally negotiated or changed under NYSHIP:

1. A Participating Agency cannot withdraw only Medicare eligible enrollees from NYSHIP. (See Policy Memo 127 for additional guidance.)

2. A Participating Agency must ensure that Medicare primary enrollees & dependents are reimbursed the full cost of the standard Part B Medicare premium. (See Section 3.8, Medicare)

3. A Participating Agency must offer dependent survivor coverage to eligible dependents if the deceased enrollee had 10 years of service. (See Sec. 3.10)

4. A Participating Agency must abide by NYSHIP's rules regarding vesting for health insurance purposes. (See Section 3.14) It is very important that Participating Agencies thoroughly understand this rule. The only limitation an Agency can place on vesting is to restrict vesting to within five years of retirement. The agency must adopt this restriction by resolution or administratively.

5. NYSHIP does not require years of service to be continuous to qualify for health insurance in retirement. NYSHIP recognizes an enrollee's total years of service irregardless of how that service is accumulated.

6. A Participating Agency cannot restrict health insurance benefits to Individual coverage only. That is, employees/retirees must be permitted to select Family coverage if they so choose and have eligible dependents.

Retirement (Section 3.7)

1. Participating Agencies which elected to participate in NYSHIP prior to March 1, 1972, are required to continue coverage for specified enrollees during retirement. Such agencies may elect to extend coverage to other retirees either administratively or as a result of collective negotiations.

2. Participating Agencies which elected to participate in NYSHIP on or after March 1, 1972, may elect to extend coverage on behalf of retirees either administratively or as a result of collective negotiations, but are not required to do so.

3. Participating Agencies which elect to extend coverage to retirees have the option of doing so for a class or classes of employees or for all employees. A Participating Agency which has elected not to extend coverage to retirees at the time of initial entry into NYSHIP may do so at a later date.

4. Participating Agencies which have provided coverage for their retirees may elect administratively or through collective negotiations to discontinue coverage during retirement for all employees or all employees of a class or category hired after a specified date in the future. (See Section 3.7)

5. Retirees are not considered part of any negotiating unit. Before retirement, however, employees participating in a particular negotiating unit have the right to negotiate for certain conditions which may be extended into retirement. For example, while they are actively employed, employees may negotiate contribution rates which will apply during retirement. In the absence of such agreement, a Participating Agency may retain or adjust existing contribution rates by administrative action, subject to the minimum contribution rate required by the laws governing NYSHIP.

Role of the Health Benefits Administrator

Employee satisfaction with health insurance coverage can best be assured when enrollees can obtain information and assistance through personal contact in their own agency. Each Participating Agency must designate a Health Benefits Administrator (HBA) who is assigned the responsibility for the administration of the New York State Health Insurance Program (NYSHIP) in that agency.

The Health Benefits Administrator's responsibilities include:

1. Ensure that all eligible employees and retirees are properly informed of the benefits and availability of NYSHIP.

2. Determine the eligibility of employees and retirees for enrollment in NYSHIP.

3. Enroll employees and eligible dependents in NYSHIP.

To report new enrollments and changes in enrollee coverage or status under the program, the HBA must complete and process the Health Insurance Transaction forms (PS-503.1) on NYBEAS (New York Benefits Eligibility Accounting System). NYBEAS is mandated for agencies that prepare 35 or more transactions per year; optional for others. Agencies that prepare fewer than 35 transactions per year will receive information on how to sign up for NYBEAS. Other responsibilities include:

1. Transmit timely premium payments on a monthly basis to the New York State Department of Civil Service in a PS 1409 envelope along with the remittance page of the bill (last page of bill);

2. Verify the accuracy of the Health Insurance Transaction Listing and Monthly Billing Statement;

3. Notify and enroll persons eligible for either COBRA or New York State Continuation of Coverage;

4. Initiate Medicare reimbursements to enrollees and dependents who become eligible for primary benefits under Medicare;

5. Maintain up-to-date files of health insurance records by verifying the reconciliation listing received quarterly;

6. Provide assistance to enrollees who have problems with claims or other aspects of their health insurance coverage.

Distribution of Materials & Commonly Used Forms

Materials for Agencies

1. At the time an Agency's resolution to participate in the New York State Health Insurance Program (NYSHIP) is approved, the Employee Benefits Division will forward a supply of the following enrollment materials and descriptive literature, including:

    a. General Information Book and Empire Plan Certificate (GIB/EP) describing the benefits available under NYSHIP. This booklet also serves as the enrollee's certificate under group contract. No separate certificates are issued.

    b. Empire Plan Reports – Amendments to GIB/EP Certificate are included.

    c. Participating Provider Directories.

    d. The New York State Health Insurance Program (NYSHIP) Manual of Procedures for Participating Agencies.

    e. Forms**:**

Form PS-503.1	Health Insurance Transaction Form
Form PS-451	Statement of Disability
Form PS-452	Application for Waiver of Premium
Form PS 452I	Instructions for application of Waiver of Premium
Form PS-516	Health Insurance Transaction Transmittal
Form IRM-302	Information Resource Management (NYBEAS) EBD Online Information Sheet
Form PS-1409	Premium Submission Envelope
Form PS-565	Participating Agency Supply Request
Form PS-457	Statement of Dependence

2. All Forms are available on the New York State Department of Civil Service Website (www.cs.state.ny.us) or by completing and submitting a Supply Request form (PS-565).

Material for Employees

1. Each new employee who is eligible to enroll in NYSHIP must be issued copies of the General Information Book/Empire Plan Certificate and a Health Insurance Transaction form (PS-503.1). It is preferable to have a distribution method that documents the enrollee's receipt of the material; a record of either

first class mail or a signed and dated acknowledgement form should be retained in the enrollee's file.

2. If an employee indicates that he or she does not wish to enroll in the program, they should complete and sign section 10, item C of the PS 503.1 to decline coverage. (See Section 2.6)

3. Following the processing of the employee's enrollment on NYBEAS, the enrollee will receive, within two to three weeks, their health insurance identification cards (one card if individual coverage, two cards if family coverage). They will be mailed directly to the employee's home. (See Section 2.8)

Employee Eligibility Requirements

1. A person appointed or elected to a position in a Participating Agency is eligible to apply for enrollment immediately upon employment if it is anticipated the person will be employed for at least three months and in addition, the employee:

   a. works a regularly scheduled workweek of 20 hours or more;

      A Participating Agency may establish a minimum workweek of more than 20 hours for the purpose of determining eligibility. When established, the new criteria may be applied to all employees, limited to certain classes or categories of employees, or applied only to employees hired after a specified date. The Participating Agency must notify the Employee Benefits Division of any increased eligibility requirements.

      or

   b. is paid at least $2,000 per year on an annual salary basis;

      A Participating Agency may establish a minimum annual salary base greater than $2,000 per year. When established, the new criteria may be applied to all employees, limited to certain classes or categories of employees, or applied only to employees hired after a specified date. The Participating Agency must notify the Employee Benefits Division of any increased annual salary base established for the purpose of determining eligibility.

      or

   c. is an elected official, or a paid or unpaid member of a public legislative body, or a publicly elected member of a school board;

      1) The determination of eligibility for such official or member is at the discretion of the Participating Agency. The agency may choose not to provide coverage for such employees or may require them to meet established workweek or annual salary eligibility criteria.

      2) Eligible school board members who elect coverage are required to pay both the employer and employee contribution.

      3) Eligible unpaid board members may be required to pay both the employee and employer share at the discretion of the agency.

      or

   d. is an unpaid local elected official or board member of a Public Authority;

      The determination of eligibility for such official or board member is at the discretion of the Participating Agency. Any such unpaid local elective official who occupies a position which by statute, local law, ordinance or resolution is

expressly prohibited from receiving compensation, shall be required to pay both the employer and the employee contribution for coverage under the plan. Civil Service Law mandates that an unpaid board member of a public authority serve in such position for six months before he/she is eligible for NYSHIP.

or

e. is a person whose major source of family income is from his or her public employment;

In this case, the burden of proof of family income is on the employee.

2. Employees in the following categories are not eligible to enroll in the program even though they otherwise meet the above requirements:

   a. Any person whose employment is scheduled for termination, other than by retirement, within three months after the effective date of the extension of the plan to employees of the Participating Agency.

   b. Any person appointed or elected for a term of less than three months; or, if a Participating Agency elects to establish such additional requirement, any employee hired for an anticipated period of less than six months.

   c. Any person who is employed by a public educational institution on other than a full-time basis and who is also a student therein enrolled for a degree.

   d. Any person who retired prior to the effective date of the extension of the plan to employees of the Participating Agency and who is subsequently reemployed in a temporary, seasonal or occasional basis.

   e. Any employee who is already covered as an enrollee under this program.

3. An employee who does not meet the eligibility requirements outlined above at the time of initial employment may later acquire eligibility by virtue of a change in employment status. Such employees should be treated as though they were new employees on the date the employment status changed. Eligibility for coverage would be determined based on the agency's policy for other new employees in the same class or category.

4. Employees who do not meet the eligibility requirements outlined in this section are **not** eligible to enroll in NYSHIP even by paying the full cost of coverage.

5. If the regularly scheduled workweek of an enrolled employee is reduced to less than 20 hours, the President of the New York State Civil Service Commission may grant extensions not exceeding one year each during which such enrolled employee's eligibility may be deemed to continue.

   a. To be considered for such extension, the Participating Agency must anticipate the reestablishment of a workweek of 20 hours or more within one year.

b. The Participating Agency may submit requests for such extensions to the Director of the Employee Benefits Division, New York State Department of Civil Service, Alfred E. Smith State Office Building, Albany, New York 12239.

6. If a Participating Agency raises the minimum workweek requirement or the annual salary requirement and an enrolled employee (not otherwise eligible) loses eligibility because of the increase, the employee's coverage must be terminated on the same basis as an employee who separates from service. (See Section 3.9)

Dependent Eligibility Requirements

1. Definitions

   a. The term “Dependent” means an employee’s

      1) Spouse.

         A legally separated spouse may be a covered dependent.

         A divorced spouse is not an eligible dependent.

      2) A child under 26 years of age.

         a. The term “child” includes natural children, legally adopted children, stepchildren, children of domestic partners, and children in a waiting period prior to finalization of adoption.

         b. “Other” children who reside permanently in the employee’s household and who are chiefly dependent on the employee and for when such support and residence began before age 19 may also be covered. Coverage will begin once enrollee has completed a Statement of Dependence Form (PS-457) for “other” children and the HBA has approved the application. The enrollee must re-certify “other” children every two years.

      3) A child 26 years of age or older who is incapable of self-support by reason of mental or physical disability and who became so incapable prior to their loss of eligibility under the Program. (See Section 2.3)

      4) An unmarried child 26 to 30 years of age who has creditable military service, is not eligible for other group employer coverage and is a full-time student at an accredited secondary or preparatory school. Time spent in the military, not to exceed four years, shall be subtracted from the age of such child for purposes of determining the maximum age for student dependent eligibility.

         a. In the event a child has had eligibility extended by virtue of military service, the child’s last day of coverage will be the last day of such extension, unless eligibility ceases at an earlier date for any other reason.

         b. In the event a student **enrolls** in school and does not enter or return to school, coverage under the parent’s policy will terminate on the last day of the month in which the enrollee notifies the Health Benefits Administrator that the child will not be continuing as a full-time student.

c. Students who enroll for the fall but do not attend must provide proof of enrollment in the previous spring semester, such as a grade transcript or tuition receipt. If proof is not provided, coverage as a dependent student under the parent's policy will terminate on the last day of the month in which the child was a full-time student. If a dependent child who was a full-time student in the spring semester does not enroll as a full-time student for the fall, coverage under the parent's policy will end on the last day of the month in which the student was a full-time student attending classes.

d. In the event a student withdraws from school for reasons other than a medical leave of absence, the last day of coverage will be the last day of the month in which the withdrawal takes place.

e. In the event the child marries, the last day of coverage will be the last day of the month in which the marriage takes place.

f. In the event the student child becomes eligible for group health insurance coverage with an employer, NYSHIP coverage ceases on the last day of the month prior to the month in which eligibility begins for the equivalent group health insurance coverage, or, if the enrollee requests, the end of the month in which eligibility for equivalent group health insurance coverage begins.

5) Domestic Partner Coverage is optional for Participating Agencies (See Section 2.5)

b. Enrollees requesting family coverage must produce proof of the relationship of the dependents for whom coverage is being requested:

1) For spouses: Copies of: birth certificate, marriage certificate, social security number, proof of joint ownership/joint financial obligation if the marriage took place more than a year prior to the request to add the spouse to coverage.

2) For domestic partners: Completed *Application for Domestic Partner Benefits* (PS-427.1) and *Dependent Tax Affidavit for Domestic Partners* (PS-427.3) and the applicable proofs as outlined in *Instructions for Enrolling Domestic Partners* (PS-427), and birth certificate and social security number.

3) For natural children: child's birth certificate and social security number.

4) For adopted children: adoption papers, child's birth certificate, social security number.

5) For a child who is a full-time student with military service 26 to 30 years of age: Enrollees must provide written documentation from the U.S. Military (the DD-214 Release or Discharge from Active Duty form)

showing the dates of service and proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution for each semester enrolled.

6) For "other children": Completed PS-457, copies of birth certificate and social security card, and documentation of support and residence as outlined in Policy Memo 88.

2. The employee must complete a Statement of Dependence Form (PS-457), if they are applying for coverage on behalf of a dependent who is other than the employee's spouse or own child, adopted child, or dependent stepchild. e.g. a grandchild

a. The employee must return the completed form to the agency Health Benefits Administrator. The Health Benefits Administrator will review the form and approve or disapprove the dependent based on the "other children" eligibility criteria. Particular attention should be paid to the following:

1) If the dependent is 26 years of age or older and disabled, it will be necessary for the employee also to submit a completed Statement of Disability-Dependent 26 Years of Age or Older form (PS-451). In this case, the procedures set forth in Section 2.3 must be completed before final approval can be given.

2) The dependent must reside permanently in the employee's home. Residence of a temporary nature or limited duration, as in the case of an exchange student, is not sufficient to provide eligibility for coverage.

3) The effective date of coverage of such eligible dependents will be the employee's effective date of Individual and Dependent (i.e., Family) coverage or date of acquisition of the dependent, whichever is later. Requests for enrollment of "other children" past the date of first eligibility are subject to late enrollment rules.

3. A spouse or child who is an eligible dependent on the date the employee is first eligible for coverage may be enrolled at the same time the employee enrolls.

4. An eligible spouse or child acquired by an employee who is enrolled for Individual coverage acquires first eligibility for enrollment on the date they first becomes the dependent of the enrolled employee.

5. Any eligible dependent acquired by an employee who is already enrolled for Family coverage is covered on the date he or she becomes a dependent under the plan definitions.

a. A new dependent child must be added to the enrollee's record on NYBEAS (for Agencies without access, submit information to the Employee Benefits Division).

b. A newly acquired spouse must also be added to the enrollee's record on NYBEAS (for Agencies without access, submit information to the Employee Benefits Division).

6. In no event will an individual specified in the following items be a dependent under the New York State Health Insurance Program:

   a. Any person who does not specifically meet one of the criteria outlined above for coverage as a dependent, e.g., parents or grandparents.
   b. Any person who is in the armed forces of any country including students in an armed forces military academy of any country.

Disabled Dependent 26 Years of Age or Older

1. An unmarried child of age 26 or older may be covered as a dependent if the child is incapable of self-support by reason of mental or physical disability, provided the child became so incapable prior to their loss of eligibility under the New York State Health Insurance Program.

2. The eligibility of a disabled dependent should be established as soon as possible as follows:

   a. Before the child reaches age 26,

   b. At the time the disability first occurs if the child is a dependent,

   c. At the time of the parent's initial enrollment in the Program if the child is 26 years of age or older.

      Note that in the case of a new enrollment, the child must have been disabled at the time they would have been considered an eligible dependent had coverage been in effect; e.g., the child became disabled prior to the 26th birthday or while they met the eligibility requirement for dependent child status.

   Prompt establishment of eligibility will avoid delays in benefits being provided to eligible disabled dependents.

3. The procedures for establishing eligibility for a disabled dependent are as follows:

   a. The Health Benefit Administrator completes Part B of a Statement of Disability-Dependent 26 Years of Age or Older form (PS-451) and gives the form to the employee.

   b. The employee completes Part A of the form and has the attending physician complete Part C. The physician then sends the completed form directly to the Empire Plan's medical carrier.

   c. The Empire Plan's medical carrier will notify the Employee Benefits Division whether the child's medical condition satisfies the Plan requirement for continued coverage.

   d. Employee Benefits Division will review non-medical aspects of dependent eligibility and enter eligibility approval into NYBEAS.

4. If the approval is for a limited period of time, the employee may submit a new Statement of Disability-Dependent 26 Years of Age or Older form (PS-451) prior to the end of the approved period.

Prior Retiree Eligibility Requirements

1. Prior Retirees are retirees who left the service of an employer prior to the employer's initial coverage date as a Participating Agency under the New York State Health Insurance Program.

   Extension of coverage to Prior Retirees is *optional* for a Participating Agency.

2. If a Participating Agency elects to extend coverage to Prior Retirees, a Prior Retiree must meet the following conditions to be eligible for such coverage:

   a. The Prior Retiree must have retired prior to the initial coverage date established for his or her Participating Agency,

   and

   b. The Prior Retiree must have been employed for at least five years by the Participating Agency from which he or she retired (such employment need not have been continuous),

   and

   c. The Prior Retiree must be receiving a retirement allowance or pension from a retirement system administered by the Participating Agency or by the State of New York (including New York State Teachers' Retirement System).

      A Prior Retiree who has returned to service and terminated his or her status as a retiree may be eligible for enrollment in the program for active employees.

3. A Prior Retiree, covered as a dependent under the New York State Health Insurance Program on the Initial Coverage Date for this group, who subsequently loses eligibility for coverage as a dependent, may at that time apply for coverage as a Prior Retiree. An application for such coverage must be made by the Prior Retiree within one month following the end of coverage as a dependent.

   In such cases, coverage as a Prior Retiree will become effective on the first day of the month following the month in which application is made.

4. All Prior Retirees must enroll for coverage as of the first date on which coverage is available to this group.

   A Participating Agency may for good cause and with prior approval of the President of the New York State Civil Service Commission allow such Prior Retirees to enroll after that date, but in no case more than ninety days after the date.

Domestic Partner Option

In 1995, New York State reached an agreement with representatives of all State employee bargaining units to extend health care coverage to domestic partners of State employees. This benefit was also extended to non-represented State employees and is offered, **on an optional basis,** to Participating Agencies. If a Participating Agency elects to offer domestic partner coverage, the Agency must adhere to the domestic partnership benefit eligibility requirements collectively negotiated by the State unions; these requirements can not be changed by the Agency.

A Participating Agency has the **option** to extend domestic partner availability to all employees and retirees or to classes or categories of active employees (e.g., may elect to offer to teachers and not offer to other staff) as well as non-active employees (retirees, vestees). The contribution rate for Family coverage that includes a domestic partner cannot differ from the Agency's rate for other Family coverage.

Who is eligible to be covered as a Domestic Partner?
An unmarried enrollee may cover a same or opposite sex partner if the enrollee can document that:

1. They have resided together for at least six (6) months;

2. They have a committed, long term relationship of mutual support;

3. They have assumed a long term financial responsibility or have mutual financial responsibility.

Persons who live together for economic reasons, but who have not made a commitment to an exclusive enduring domestic partner relationship **will not** be considered to be domestic partners.

If a Participating Agency chooses to elect Domestic Partner coverage, they should:

1. Send a copy of the official resolution or other written confirmation of the decision to offer Domestic Partner coverage to the Employee Benefits Division with an effective date.

2. Contact the Employee Benefits Division to request a Domestic Partner package.

3. Have the enrollee complete the Domestic Partner packet with the appropriate proofs and return the completed packet to their Agency. The Agency determines if the packet is complete and, if so, enrolls the domestic partner. Agencies with any questions about domestic partner eligibility may contact the Employee Benefits Division.

Employers that contemplate providing this benefit should seek expert tax advice so that they are fully aware of the tax implications and reporting requirements for both employers and employees, and can provide accurate information on the tax implications to enrollees.

Processing Enrollments and Declinations

1. *Enrollments*

   a. Verify that the employee meets the eligibility requirements for coverage in the New York State Health Insurance Program (See Section 2.1).

   b. The employee and Health Benefits Administrator complete a Health Insurance Transaction Form (PS-503.1). Review the form to ensure that all required items have been completed and that the employee has signed and dated the form. The form will not be processed without a signature and date.

   c. If the employee is enrolling for Family coverage, review the list of dependents for conformity with the following:

      1) The name, relationship, social security number, and date of birth must be completed and documented for each dependent listed on the form. (See Section 2.2, #1.c for required proofs of relationships.)

      2) Only those persons defined as eligible dependents with proper documentation may be listed. If ineligible dependents such as parents have been listed, the names of such ineligible dependents should be deleted and the employee notified of the deletion.

      3) If a dependent other than a spouse or natural child, adopted child, dependent stepchild, or child in the final waiting period prior to finalization of adoption is listed, a Statement of Dependence form (PS-457) must be completed (See Section 2.2, #2).

      4) When an employee has listed a dependent child age 19 or older who may be eligible by reason of disability or as a full-time student, follow the procedures set forth in Section 2.3 to establish eligibility for coverage for such child. **In the case of a disabled dependent, eligibility must be established at the time of initial enrollment if the dependent is already 19 years of age or older.**

   d. Determine the employee's effective date of coverage in accordance with Section 2.7.

2. *Declinations:*

   a. If an employee does not wish to enroll in the New York State Health Insurance Program at the time of initial eligibility (See Section 2.1), he or she should be required to complete the Declination of Health Insurance section (10C) on the PS-503.1.

      This form serves two purposes:

1) It directs the employee's attention to the fact that the effective date of his or her coverage may be deferred for a period of time if he or she request coverage at a later date (See Section 2.7).

2) It provides a permanent record of the fact that the employee has been advised of his or her eligibility for enrollment, and he or she chose not to enroll when first eligible.

b. The completed form should be retained by the Participating Agency.

Effective Date of Coverage

Employee Coverage

1. A Participating Agency may provide coverage for an eligible employee on the date his or her employment begins or may, at its discretion, require the employee to satisfy a waiting period, not to exceed six months, before coverage for the employee and any eligible dependents becomes effective.

   First Date of Eligibility – This date is the earliest date an employee may have coverage effective under the program. The first date of eligibility and the date an employee applies for coverage determine the effective date of coverage as explained below.

   The policy that establishes an employee's first date of eligibility must be applied on a uniform basis within the agency or within a class or category for all new employees or newly eligible employees.

   With the exception of a policy which provides coverage on the date of employment, the first date of eligibility as well as the effective date of coverage for a new employee or newly eligible employee must be the first date of a month.

2. The following procedures apply when assigning an employee's effective date of coverage:

   a. If an employee applies for coverage on or before the first date of eligibility assigned by the Participating Agency, the effective date is the first date of eligibility.

      Example A: An employee is hired on April 15 in an agency which permits coverage on the date of employment. The employee applies for coverage prior to April 15. The effective date of coverage is April 15.

      Although the employee in Example A will have coverage for only a portion of April, the Participating Agency will be charged for the full monthly premium. Benefits under the Program will be available only for health services received on or after the effective date of coverage.

      Example B: An employee is hired on April 15 in an agency which requires one full month of employment before coverage may become effective. In this case, the first date of eligibility is June 1 since the first date of eligibility must be the first day of a month. The employee applies for coverage on April 14. The effective date of coverage is June 1.

   b. If an employee applies for coverage within one month after the first date of eligibility, coverage is effective the first day of the month following the month in which the employee applies for coverage.

Example: An employee is hired on April 15 in an agency which requires one full month of employment before coverage becomes effective. The first date of eligibility is June 1. The employee applies for coverage on June 10. The effective date of coverage is July 1.

c. If an employee applies for coverage more than one month after the first date of eligibility, coverage becomes effective the first day of the third month following the month in which the employee applies for coverage.

Example: An employee is hired on April 15. The date of first eligibility is June 1. The employee applies for coverage on July 6. The effective date of coverage is October 1.

3. Special Situations

a. An employee who is hired on or otherwise acquires eligibility on the first day of a month may count that month in establishing the effective date of coverage.

b. An employee who is not eligible for coverage may later become eligible due to a change in employment status. When this occurs, the first date of eligibility is determined as if the date on which the employment status changed were the initial date of employment of a newly hired eligible employee.

Example: An employee is hired on April 15 but is ineligible for coverage because the employee does not work a sufficient number of hours per week. On August 15, the employee's hours are increased to make the employee eligible for coverage. The employing agency requires one full month of eligible employment before coverage may become effective. In this case, the first date of eligibility is October 1. The employee applies for coverage on August 15. The effective date is October 1.

c. If an employee applies for coverage prior to a Participating Agency's Initial Coverage Date, coverage will become effective on the Initial Coverage Date.

d. An employee who is eligible for coverage may choose not to enroll because the employee is covered under another health plan; e.g., the employee is covered as a dependent on the spouse's plan. If the employee's coverage under the other plan ends, the employee may enroll under the New York State Health Insurance Program without being subject to the normal waiting period for late enrollment, provided an application is made within 30 days of the end of the other coverage.

1) The following procedures apply to enroll such an employee:

(a) The employee obtains documentation from the former insurer which indicates that he or she had coverage and the termination date of coverage. (e.g., HIPAA creditable coverage letter.)

2) The effective date of coverage will be determined as follows by the Enrollment System:

(a) If the request for coverage is made on or before the date the other coverage ends, coverage will become effective on the day following the date the other coverage ends.

(b) If the request for coverage is made no more than one month after the other coverage ends, coverage will become effective on the first day of the month following the month in which the employee requests coverage.

(c) If the request for coverage is made more than one month after the other coverage ends, the coverage will become effective the first day of the third month following the month in which the employee requests coverage.

Dependent Coverage

1. Before a Health Benefits Administrator can assign an effective date for Family coverage, the employee's date of first eligibility for such coverage must be established. This is determined by the "date of event" which is the date an employee acquires his or her first eligible dependent.

2. The following procedures apply when assigning an effective date for Family coverage:

a. If an employee applies for Family coverage when he or she first enrolls in the program, the effective date of coverage for the dependent(s) will be the same as the employee's effective date of coverage.

b. If an employee currently enrolled with Individual coverage applies for Family coverage prior to the date of first eligibility for Family coverage, coverage becomes effective on the "date of event".

Example: An employee will be married on June 10 and applies for a change from Individual to Family coverage on May 31. Family coverage will become effective June 10 (the "date of event" is the date of marriage).

In cases where the effective date for Family coverage is other than the first day of a month, the Family premium for the full month must be paid, although benefits will be payable only for services rendered on or after the effective date of Family coverage.

c. If an employee currently enrolled for Individual coverage applies for Family coverage within one month of the event, the effective date of coverage is the first day of the month following the qualifying event in which Family coverage was requested.

Example A: An employee is married on June 10 and applies for a change from Individual to Family coverage on June 25. Family coverage will become effective on July 1.

Example B: An employee is married on June 10 and applies for a change from Individual to Family coverage on July 1. Family coverage will become effective on July 1.

Example C: An employee is married on June 10 and applies for a change from Individual to Family coverage on July 3. Family coverage would be come effective August 1.

d. If an employee currently enrolled for Individual coverage applies for Family coverage more than one month after the date of first eligibility for Family coverage, the effective date for Family coverage is the first day of the third month following the month in which the employee requests Family coverage.

Example: An employee is married on June 10 and applies for a change from Individual to Family coverage on September 5. Family coverage will become effective December 1.

3. Special Situations

a. If an employee currently enrolled for Individual coverage acquires a newborn child through birth or adoption, the child may be covered as of the date of birth in accordance with the following:

1) If the employee is the birth parent, the employee must apply for a change to Family coverage within 30 days of the child's date of birth.

2) If the employee acquires a child though adoption and (i) legal guardianship has been established as of the date of birth or (ii) a petition for adoption has been filed pursuant to Section 115 of the Domestic Relations Law prior to, or within 30 days of birth, the employee must apply for a change to Family coverage within 30 days of the child's date of birth.

(a) The date of birth of the newborn is not counted in calculating the 30 day timely enrollment period. For example, if an employee's child is born on July 1, the employee may apply for Family coverage on that day or from July 2 through July 31; and the effective date will be July 1.

(b) Once coverage is changed to Family coverage due to the addition of a family member, any other eligible dependent can be added.

(c) If application for Family coverage is made more than 30 days after the newborn's date of birth, dependent coverage will

become effective on the first day of the third month following the month within which application is made.

b. If an employee currently enrolled for Individual coverage applies for a change to Family coverage because his or her spouse's health insurance coverage ends, the effective date of Family coverage is determined as follows:

1) If the request is made on or before the date the spouse's coverage ends, Family coverage will become effective on the day following the date the spouse's coverage ends.

2) If the request is made within one month after the date the spouse's coverage ends, Family coverage will become effective on the first day of the month following the date of request.

3) If the request is made more than one month after the date the spouse's coverage ends, Family coverage will become effective the first day of the third month following the month in which the request is made.

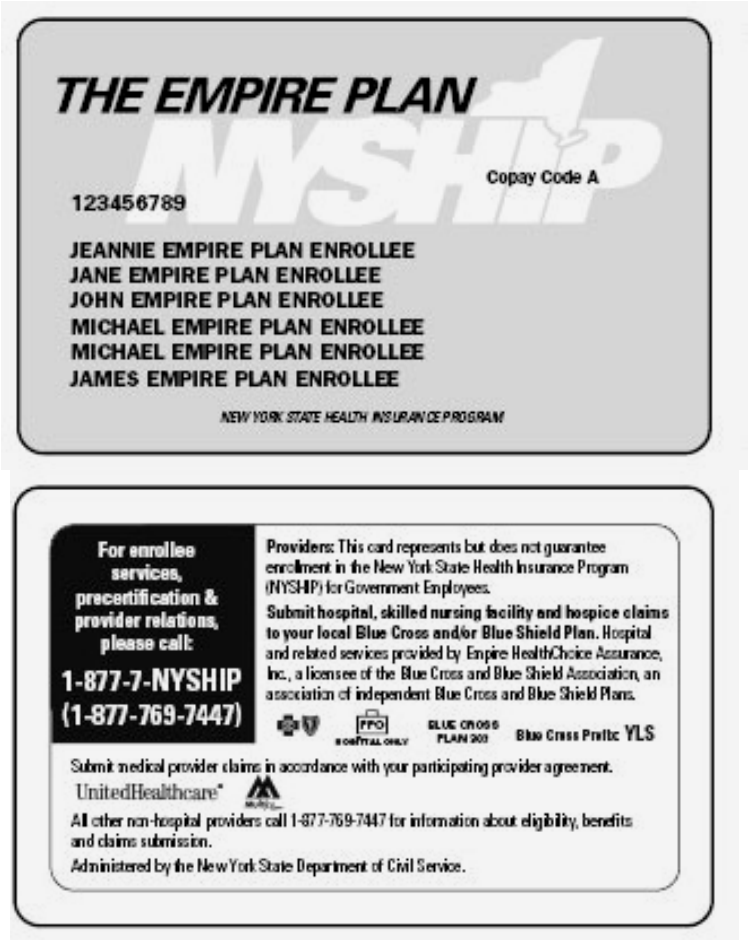
Employee Benefit Cards

Overview

Empire Plan Identification Cards are issued after an enrollment has been processed. The same card is used to access all health benefits. Enrollees will receive one card for Individual coverage, and two identical cards for Family coverage. In the case of Family coverage, the enrollee and up to five dependents will be listed on the card. If there are more than six family members, two cards will be issued. Additional or replacement cards can be ordered by the Health Benefits Administrator. Cards will take approximately two to three weeks to arrive by mail. On the front of the card, an alternate ID number is issued. Social Security numbers are no longer used. This alternate ID number is the enrollee's identification number related to their Empire Plan benefits.

Use of the Card

The card becomes valid on the date the enrollee's benefits go into effect. There is no expiration date on the card because the Enrollment System is continually updated to reflect changes in enrollment status. It is the enrollee's responsibility to notify the agency's HBA promptly if the enrollee or dependents are no longer eligible for NYSHIP coverage. If the enrollee or dependents use the card when no longer eligible for benefits, the enrollee will be responsible for paying all expenses incurred after eligibility ends. Use of the card after eligibility ends constitutes fraud.



Change of Coverage

Pre-Tax Contribution and Changes in Coverage

If the Participating Agency requires an employee contribution and deducts the NYSHIP premium from their enrollees on a pre-tax basis, there are limitations on when enrollees can change their health insurance coverage during the tax year. In general, Internal Revenue Service regulations require an employer to take a fixed pre-tax contribution toward an employee's coverage throughout the year unless a qualifying change in status event occurs.

While certain changes in coverage are permitted under NYSHIP rules "at any time," enrollees participating in an agency's pre-tax contribution program may find it to their financial advantage to wait until the end of the tax year to make changes in coverage if the IRS limitations on changes in deductions apply to those changes. The Agency should consult with their tax professional.

Change of Coverage: Individual to Family or Family to Individual

1. An employee or retiree may apply for a change from Individual to Family or Family to Individual coverage at any time.

   If an employee or retiree no longer has eligible dependents, the enrollee must change his or her coverage from Family to Individual.

2. To change coverage, prepare and submit a Health Insurance Transaction form (PS-503.1) with the appropriate transaction to NYBEAS.

   a. The enrollee should indicate the reason for the change and the date of event on the transaction form. **The enrollee must also provide proper documentation to support proof of the relationship for dependents.** (See Section 2.2)

   b. For a change to Family coverage

      1) If a dependent is other than the enrollee's spouse, natural born child, adopted child, or dependent stepchild, the enrollee must complete a Statement of Dependence form (PS-457; refer to Section 2.2) A separate form must be completed for each such dependent.

      2) If a dependent being added is 19 years of age or older and is disabled, a Statement of Disability Dependent 19 Years of Age or Older form (PS-451) must be completed (See Section 2.3).

   c. Determine the effective date of Family or Individual coverage in accordance with Section 2.7.

Changes in Coverage when both spouses are enrolled in NYSHIP

When a husband and wife are each enrolled in the New York State Health Insurance Program with Individual coverage through their employers (Participating Agency, Participating Employer, or State Agency), either spouse may change to Family coverage and include the other spouse as a dependent at any time. (Dual Family coverage is not permitted if one is employed by a State Agency.) Although the other spouse is eligible to continue with Individual coverage, he or she may choose to cancel his or her Individual coverage and be covered only as a dependent of the spouse enrolling with Family coverage. In such cases, the spouse who cancels Individual coverage may reapply for coverage as an enrollee at any later date provided he or she is still eligible for such coverage.

1. Changing from Two Individual Coverages to One Family Coverage

   a. The spouse who wishes to be covered as a dependent only must complete a transaction form requesting cancellation of Individual coverage.

      If such spouse is an employee or retiree of the Participating Agency, prepare and submit a Health Insurance Transaction form (PS-503.1) with the appropriate cancellation transaction.

   b. The spouse changing to Family coverage must complete a transaction form indicating the reason for change and date of event.

   c. If the husband and wife are employed by or retired from different agencies, the Health Benefits Administrators of the two agencies should coordinate their efforts to avoid any possible lapse in coverage.

2. Changing from Family Coverage to Two Individual Coverages

   a. If the sole dependent of an enrollee is also an eligible employee or retiree of a Participating Agency, Participating Employer, or State Agency but not already covered as an employee or retiree in NYSHIP, Family coverage may be changed to two Individual coverages as permitted by pre-tax regulations.

   b. To change from Family Coverage to Two Individual Coverages:

      1. The spouse enrolled with Family coverage must complete a transaction form requesting Individual coverage with the date of event and the reason for the change. If the spouse is an employee or retiree of a Participating Agency, have them submit a Health Insurance Transaction Form (PS-503.1) requesting Individual coverage. (Note: If the spouse had previous coverage under NYSHIP, please note on transaction form.)

      2. For a timely enrollment, the effective date of the Individual coverage of each Participating Agency enrollee will be the first day of the month following the month the change is requested (see Section 2.7).

3. If the enrollee and his or her dependent are employed by or retired from different agencies, the Health Benefits Administrators of the two agencies should coordinate their efforts to avoid any possible lapse in coverage.

3. Transfer of Family Coverage

a. When the spouse of an employee enrolled for Family Coverage is also an eligible employee or retiree of a Participating Agency, Participating Employer, or State Agency but not already covered as an employee or retiree in the New York State Health Insurance Program, coverage may be transferred from the currently enrolled spouse to the dependent spouse .

1) The spouse currently enrolled with Family coverage must complete a transaction form requesting cancellation of coverage; or, if the employee is terminating his or her employment, a transaction form (PS-503.1) must be completed indicating termination of coverage as permitted by pre-tax regulations.

2) The spouse currently enrolled only as a dependent must complete a transaction form (PS-503.1) enrolling in Family coverage and indicating previous coverage under the New York State Health Insurance Program.

If such spouse is an employee or retiree of the Participating Agency, prepare and submit a Health Insurance Transaction Form (PS-503.1) with the appropriate transaction to NYBEAS.

3) If the husband and wife are employed by or retired from different agencies, the Health Benefits Administrators of the two agencies should coordinate their efforts to avoid any possible lapse in coverage.

Health Insurance Buyouts

If Participating Agencies offer buyouts of NYSHIP coverage, they must do so on an annual basis and only for those who have other coverage available to them. Employees who accept the buyout will not be allowed to re-enter NYSHIP until the end of the buyout period and must enroll during the annual transfer period to have coverage without a waiting period after the buyout period ends. Persons taking a buyout who lose other coverage involuntarily may regain coverage under the rules for involuntary loss of coverage.

Transfer Between Employer Sponsored Plans

Participating Agencies which offer enrollees the choice of health insurance coverage in NYSHIP's Empire Plan or in one or more Health Maintenance Organizations (HMOs) must provide enrollees the opportunity to transfer from one plan to another plan under the circumstances described below.

To avoid any possible loss of benefits, each enrollee who requests a transfer to another plan should be advised to carefully review any limitations on benefits available under the plan requested, as well as under his or her present coverage.

Annual Transfer Period

Each year, the New York State Health Insurance Program has an annual transfer period for Participating Agency enrollees.

During the transfer period, enrollees of a Participating Agency which offers a choice between the Empire Plan and one or more Health Maintenance Organizations (HMOs) are given the opportunity to transfer their health insurance coverage between the Empire Plan and another available plan, or, to change from a HMO to the Empire Plan.

Prior to the beginning of each transfer period, the Employee Benefits Division issues a memorandum to Participating Agencies with instructions on processing health insurance transactions on behalf of any enrollees who wish to change from their current health insurance plan to another available plan.

The State has adopted a policy which allows retirees to change their option once every 12 months. Participating Agencies may follow the same policy and should notify the Employee Benefits Division in writing upon adoption of this policy.

It is important to note that changing from Individual to Family coverage during the annual transfer period *will not* waive the late enrollment waiting period.

Transfer Based on Permanent Change in Residence

1. An HMO enrollee who moves permanently out of the HMO service area may transfer to the Empire Plan at any time following the change of residence.

   If such a situation occurs, obtain from the enrollee a signed letter or memorandum in which he or she requests a transfer to the Empire Plan. Keep the signed request on file to document the enrollee requested the change.

2. An HMO enrollee may change to the Empire Plan if his or her eligible dependent moves to an address outside the area served by the HMO subject to the following:

   a. The change of residence must be permanent. (e.g., dependent moves out of the HMO area to reside with parent.)

b. The change of residence occurred after the most recent Annual Transfer Period.

c. A request for an option change is made within 30 days of the change of residence.

If such a situation occurs, follow the procedures described under 1. above.

3. An enrollee with Empire Plan coverage who moves permanently into the service area of an HMO (which is offered as an alternative plan by a Participating Agency) may transfer to the HMO if the agency permits such a change.

If such a situation occurs, prepare and submit a Health Insurance Transaction form (PS-503.1) with the appropriate cancellation transaction to NYBEAS.

Temporary Removal from the Payroll Including Preferred List Status

An employee in one of the following categories may continue coverage by making direct payments to his or her Participating Agency, subject to the policies described in this section:

- Authorized leave pursuant to the federal Family and Medical Leave Act of 1993
- Military leave
- Seasonal layoff
- An employee whose services have been terminated due to the abolition of his or her job or whose name has been placed on a Civil Service preferred list for reinstatement.

1. FMLA - Family Medical Leave Act

   a. With certain exceptions, such as employers which normally employ fewer than 50 employees, all Participating Agencies are subject to the provisions of the federal Family and Medical Leave Act (FMLA) of 1993. It is strongly recommended that a Participating Agency obtain advice from a legal advisor in administering the provisions of this law.

   b. Under the FMLA, an employee is entitled to 12 weeks of unpaid leave during any 12 month period to care for a newborn, adopted or foster child or because of a serious health condition of the employee or child, spouse or parent of the employee.

2. Abolition of Position / Preferred List

   An employee whose services have been terminated due to the abolition of his or her job or whose name has been placed on a Civil Service preferred list for reinstatement may continue coverage for a maximum of one year or until reemployed by a public or private employer, whichever comes first, provided the Participating Agency elects administratively or through collective negotiations to provide such coverage.

3. Military Leave

   Ordinarily, an employee who enlists in the Armed Forces will not wish to continue coverage under the New York State Health Insurance Program (NYSHIP). The employee will be provided health services by the Armed Forces, and his or her dependents will ordinarily be eligible for a plan of health insurance coverage for dependents of military personnel. **Further, the employee is not eligible for any benefits from NYSHIP while in military service.** However, if the dependents of an employee on military leave are not eligible for health care through the Armed Forces or if for other reasons the employee simply wishes to continue their enrollment in

NYSHIP during his or her military leave, the employee may continue Family coverage while on leave from the Participating Agency.

4. Enrollee Premium Contribution

The amount of payment due from the employee is determined by the reason for the employee's temporary removal from the payroll.

a. An employee who is on authorized leave without pay, military leave without pay or on seasonal layoff must pay **both the employee and employer shares** of the premium while off the payroll; however, a Participating Agency can elect to pay all or part of military leave coverage.

b. An employee who is on an authorized leave pursuant to the federal Family and Medical Leave Act of 1993 is required to pay **only the employee share** of the premium (the same amount the enrollee would pay if working).

c. When a Participating Agency elects administratively or through collective bargaining to provide coverage for an employee whose services have been terminated due to the abolition of his or her job or whose name has been placed on a Civil Service preferred list for reinstatement, the employee is required to pay **only the employee's share** of the premium, if any.

5. When An Employee Is Going On Leave

a. Prior to the employee's last day on the payroll, he or she should be provided with full information regarding eligibility for coverage, amounts of payments, payment due dates and remittance procedures.

b. The Participating Agency must collect and establish internal controls for receipt of the required payments.

c. The Participating Agency is responsible for processing the appropriate transactions on NYBEAS.

d. If an employee fails to make the required payment while off the payroll, the employee has a 30 day grace period before coverage can be cancelled for non-payment.

6. Reinstating Coverage Following Cancellation for Non-Payment

If an employee whose coverage has been cancelled for failure to remit payments while off the payroll wishes to have coverage reinstated while still off the payroll, coverage may be reinstated as of the first day of the third month following the date he or she requests such reinstatement, provided the employee is still eligible for such coverage.

Note: See Section 3.5 for procedures to follow when an employee returns to the payroll.

Restoration to Payroll Following Temporary Removal

Coverage Continued While Off The Payroll

If an employee on authorized leave without pay, leave pursuant to the federal Family and Medical Leave Act of 1993, military leave or seasonal layoff made all required premium payments while off the payroll (See Section 3.4), health insurance premium deductions, if any, may be resumed at the time he or she returns to the payroll, and there will be no interruption in coverage.

Coverage Cancelled While Off the Payroll

If an employee's coverage was cancelled for failure to remit payments while off the payroll, it may be reinstated upon his or her return to the payroll.

1. Except for reinstatement of coverage from leave pursuant to the Family and Medical Leave Act of 1993 (see 2. below), the effective date of the reinstatement of coverage is determined as follows:

    a. If an employee applies for reinstatement on or before he or she returns to the payroll, the effective date of the reinstatement is the date of the return to the payroll.

        Example: An employee's leave without pay ends on July 15 and she will return to the payroll on July 16. On July 1, she requests reinstatement of coverage. Coverage is effective July 16.

    b. If an employee applies for reinstatement on the day he or she returns to the payroll or within one month thereafter, the effective date of the reinstatement is the first day of the month following the date of the employee's request.

        Example: An employee returns to the payroll on October 1. On October 15, he applies for reinstatement. Coverage is effective as of November 1.

    c. If an employee applies for reinstatement more than one month following his or her return to the payroll, the effective date of reinstatement is the first day of the third month following the date of request.

2. The effective date of the reinstatement of coverage for an employee who returns to the payroll from a leave pursuant to the federal Family and Medical Leave Act of 1993 or from Military Leave is the date of his or her return from leave.

    It is strongly recommended that a Participating Agency obtain advice from a legal advisor in administering the provisions of The Family and Medical Leave Act of 1993.

Waiver of Premium

A waiver of premium for a period of up to one year in duration may be granted to an employee who is totally disabled and on authorized leave without pay or, if provided by the Agency, on a preferred list. The Participating Agency will not be billed for the employee's coverage while they are in the waiver of premium status.

Eligibility for a Waiver of Premium

To be eligible for such a waiver of premium, an employee must meet all of the following conditions:

1. The employee must be totally disabled as a result of sickness or injury and have been continuously so disabled for at least three months. Totally disabled means that as a result of sickness or injury the employee is incapable of performing the duties of their job.

2. The employee is on authorized leave without pay or the employee's name is on a Civil Service preferred list for reinstatement.

   Note that a person whose name is on a Civil Service preferred list may be eligible for a waiver of premium only if their former employer has elected as a Participating Agency to provide such coverage. (See Section 3.4)

3. The employee must have kept coverage in effect during the period they have been off the payroll.

   An employee must apply for a waiver of premium when they currently meet the eligibility requirements. Applications for retroactive waivers of premiums will not be approved.

Procedures for Instituting a Waiver of Premium

1. The employee completes Part A of the Application for Waiver of Premium (PS-452).

2. The Health Benefits Administrator of the employee's Participating Agency completes Part B of the PS-452.

3. The employee's attending physician completes Part D of the PS-452 and mails the form directly to the Empire Plan's medical carrier. The carrier notifies the Employee Benefits Division of their determination on the application. The Employee Benefits Division processes the waiver and notifies the Health Benefits Administrator in writing. It is the responsibility of the Health Benefits Administrator to notify the enrollee of the decision and refund any monies due.

Duration of the Waiver of Premium

1. If approved, a waiver of premium will begin on the first day of the fourth month following the occurrence of the disability or on the first day of the month following the date leave without pay began, whichever is later.

2. The waiver of premium will continue during the period of total disability, but in no event for more than one year.

3. If any of the following conditions occur during the period of the waiver, the waiver will cease:

    a. Cessation of the total disability.

    b. Return of the employee to the payroll.

    c. Approval of a request for retirement.

    d. Separation from service.

    e. Death of the employee.

    If any of the above conditions occur during the period of an employee's waiver of premium, notify the Employee Benefits Division in order to have the enrollment status changed.

Additional Waiver of Premium

1. The enrollee must return to work before being eligible for an additional waiver of premium. If the enrollee has not returned to work, he or she may not use accruals to return to the payroll for a brief period in order to qualify for an additional waiver.

2. If an enrollee receives a waiver of premium, returns to work and continues health insurance coverage, but must again take a leave without pay because of a disability, the following rules apply:

    a. If the enrollee returns to leave without pay status after working less than three consecutive months, the enrollee may resume coverage under the previous waiver for the remainder of the original one-year period which includes the time back to work.

    b. If the enrollee returns to leave without pay status after working three or more consecutive months, once the enrollee has been disabled for three months and is in leave without pay status, the enrollee may apply for a new waiver of premium for an additional one-year period.

3. There is no lifetime limit to the number of waivers an enrollee can receive. The Employee Benefits Division will notify the Participating Agency if an additional waiver has been granted.

Continuing Coverage in Retirement

1. Key Dates for Establishing Retiree Coverage

   a. If a Participating Agency joined NYSHIP prior to March 1, 1972, the enrolled employees are eligible for benefits into retirement if their most recent date of employment with the employer is prior to April 1, 1977.

   b. A Participating Agency is not required to offer retirement benefits to enrolled employees if their most recent date of employment with the employer is on or after April 1, 1977.

   c. A Participating Agency may establish a service requirement greater than 5 years for employees hired on or after April 1, 1975.

2. Regular Retirement Eligibility Rules

   An enrolled employee of a Participating Agency which elected to participate in the New York State Health Insurance Program **prior** to March 1, 1972, is eligible to continue coverage in retirement provided that he or she meets the requirements **under a., b. and c.** below.

   An enrolled employee of a Participating Agency which elected to participate in the New York State Health Insurance Program **after** March 1, 1972, is eligible to continue coverage in retirement *if* the employee is a member of a class or category of employees for which the Participating Agency has elected administratively or through collective bargaining to provide coverage in retirement and he or she meets the requirements **under a., b. and c.** below.

   Completion of the Minimum Service Period

   a. The employee had at least 5 years of service in a benefits eligible position, **not necessarily continuous**, with the Participating Agency from which he or she is retiring, subject to the following:

      1) The Participating Agency may elect administratively or through collective negotiations to establish a service requirement greater than 5 years for purposes of determining eligibility for coverage in retirement for all employees or a class or category of employees whose most recent date of employment with the employer is on or after April 1, 1975. **If a Participating Agency does not have an established service requirement, the Agency must abide by the minimum service requirement of 5 years.**

      2) If an employee has less service than established by the Participating Agency for coverage in retirement, such employer may elect administratively or through collective bargaining to provide for continuation of coverage in retirement for all employees or a class or category of employees who have met the applicable period of required

service with one or more public employers, provided the employee has served a minimum of one year with the Participating Agency from whose service he or she will retire. A Participating Agency so electing to recognize prior public service shall agree to do so for all employees or all employees in a class or category who meet the conditions specified.

Participating Agencies may recognize the previous service an employee has with another NYSHIP Participating Employer/Agency and/or the State. In addition, the employer/agency may also recognize other public service the employee has with any public employer outside NYSHIP, including the federal government or United States military. Once an agency has chosen to recognize public service outside of NYSHIP, the agency must do so for all employees or all employees in that class or category who, on retirement, have other public service.

3) Participating Agencies may count periods of service an employee has with the agency in a non-benefits eligible position toward the eligibility requirement for continuing health insurance in retirement. Such service may be prorated to a full-time equivalent (e.g., 10 years at half-time equals five years of service) at the discretion of the employer, provided the method of calculation is equitably applied. Employers who wish to adopt this policy must submit a statement of its written policy to the Employee Benefits Division.

4) The Participating Agency may elect administratively or through collective bargaining to establish as ineligible for coverage in retirement all employees or a class or category of employees whose most recent date of employment with the employer is on or after April 1, 1977.

5) If the Participating Agency elects to provide coverage in retirement for School Board Members, the retiree must have **at least 20 years** of service in that position.

6) If the Participating Agency elects to provide coverage in retirement for unpaid board members, the retiree must have **at least 20 years** of service in that position.

Membership in a Retirement System

b. The employee must satisfy either 1) or 2) below:

1) The employee is eligible to retire or has retired as a member of a retirement system administered by the State of New York or one of its political subdivisions including the New York State and Local Retirement System, New York State Teachers' Retirement System, or New York State and Local Police and Fire Retirement System or under optional retirement programs, for example, Teachers Insurance and Annuity Association/College Retirement Equities Fund (TIAA-CREF), established under article 3, part V of the Education Law;

or

2) If the employee is not a member of a retirement system administered by the State or one of its political subdivisions, one of the following conditions must be satisfied in order to continue coverage in retirement:

a. The enrollee must meet the Employee Retirement System's age requirement in effect at the time he or she last entered service. Employees who are members of certain retirement systems such as the Local Police & Fire Retirement Systems are eligible to retire after a specific number of years of service regardless of age, or;

b. The enrollee must be qualified to receive Social Security disability payments.

c. The employee is enrolled in the New York State Health Insurance Program as an enrollee or dependent, or in an alternative employer sponsored health plan offered by the agency at the time of retirement. If an employee who otherwise meets the eligibility requirements for coverage in retirement is not enrolled as an enrollee or dependent at the time of retirement, he or she may not enroll at a later date.

Note: Employees who have met the Agency's requirement for retiree health benefits and leave employment but defer receipt of a pension **must be** considered retired for health insurance purposes. Such an employee must still meet the requirements in **a.** or **b.** of this section. When an enrollee retires for health insurance purposes but delays collecting his or her pension, this is called "constructive retirement."

Note: If an employee is not yet eligible to have coverage as a retiree, he or she may be eligible to vest for health insurance purposes and continue coverage until retirement. (See Section 3.14) If an employee whose employment is terminated is not eligible to continue coverage in retirement or as a vestee, his or her coverage must be terminated. COBRA Continuation must be offered. (See Section 3.12)

3. Disability Retirement Rules

These rules only apply to Participating Agencies that offer health insurance coverage in retirement.

a. An enrolled employee who has been granted a **work-related disability retirement** by a retirement system administered by the State of New York or one of its civil divisions is eligible to continue coverage as a retiree regardless of age or length of service with the Participating Agency.

1) When an employee receives a retroactive, work-related disability retirement, and health insurance has been cancelled due to nonpayment

during a period of leave without pay necessitated by the work-related disability, the Participating Agency has the option of allowing the employee to re-enroll in NYSHIP retroactively effective on the date of retirement, or on a current basis.

b. An enrolled employee who has been granted an **ordinary** (non-work related) **disability retirement** by a retirement system administered by the State of New York or one of its civil divisions is eligible to continue coverage in retirement provided the employee meets the agency's eligibility service requirements except for age.

1) When an employee receives a retroactive, ordinary disability retirement, and health insurance has been cancelled due to non-payment during a period of leave without pay or vested status as a result of the disability, the Participating Agency has the **option** of allowing the employee to reenroll in NYSHIP (if all other eligibility requirements are met). To reinstate coverage, the employee **must** pay all missed payments (based upon coverage in effect at the time health insurance ceased) up to the effective date of the disability retirement. Then, that enrollee has a three month late enrollment waiting period based on the date the individual signed the transaction form (PS-503.1) before coverage is effective.

2) No application for reinstatement of coverage may be accepted more than one year from the date of the cover letter for the notice of determination issued by the New York State and Local Employees' Retirement System. If extenuating circumstance exist, contact the Employee Benefits Division for advice.

3) A Participating Agency should have a written policy in effect regarding disability retirement and reinstatement of NYSHIP coverage. The policy must be applied consistently in a non-discriminatory manner.

c. An enrolled employee who is not a member of any New York State retirement system who has qualified for Social Security disability payments is considered to be retired for health insurance purposes, regardless of age, provided that he or she has met the Participating Agency's service requirement. The employee must present a certificate of Social Security insurance award to the Participating Agency as proof of his or her Social Security status.

Note: For additional clarification on Disability Retirement Rules see Policy Memo 62r1 & 102r1.

4. NYSHIP Coverage as a Dependent at the Time of Retirement

An employee who meets the requirements for coverage in retirement, but who is covered under the New York State Health Insurance Program at the time of retirement as a dependent of another employee, may at any time thereafter enroll as a retiree.

5. Retirement Eligibility and Employment with Another Participating Employer

When an employee has established eligibility to continue coverage in retirement through one Participating Agency, that eligibility shall not be impaired by subsequent employment and/or enrollment through another Participating Agency, except when the employee establishes eligibility for coverage in retirement through the second employer. When such eligibility is established through the second employer, the liability of the first employer to provide coverage in retirement is terminated.

6. Re-Enrolling as a Retiree

An employee who continues coverage in retirement may elect to cancel his or her coverage and subsequently reenroll, at any time, subject to late enrollment procedures (see Section 2.7).

7. Payment of Premium by Retirees:

a. If an employee who continues coverage in retirement is a member of the New York State and Local Employee's Retirement System, the New York State and Local Policemen's and Firemen's Retirement System or the New York State Teachers' Retirement System, health insurance deductions, if any, may be taken from his or her monthly retirement allowance. The Participating Agency will remit only the employer's share of the premium each month to the Employee Benefits Division. (See list of contribution rates offered by NYSHIP, Section 1.5)

b. If an employee who continues coverage in retirement is not a member of one of the retirement systems listed under 2.b.1) above, he or she must remit the employee share of the health insurance premium, if any, directly to the Participating Agency. The Participating Agency will be billed for the entire premium and is responsible for remitting payment each month to the Employee Benefits Division.

8. Credit for Accumulated but Unused Sick Leave

A Participating Agency may elect administratively or through collective bargaining to provide an additional contribution toward the cost of a retiree's coverage on the basis of any unused sick leave accruals he or she may have at the time of retirement, provided the employee was subject to an established plan for the regular earning and accumulation of such credits. A Participating Agency must be consistent in applying their decisions regarding sick leave credit.

a. In no case may sick leave credits be applied toward health insurance premium costs either while the enrollee is in vested status or after retiring from vested status. Sick leave credits can be applied toward the premium **only** if retiring directly from active employment.

b. Such use of sick leave credits may be extended only to those who retire after the Participating Agency's election to provide this benefit. It may not be extended retroactively to employees who retired before that date.

Medicare

Medicare is a federal health insurance program for people age 65 or older, certain disabled people, and for people with end stage renal disease (kidney failure) or ALS (amyotrophic lateral sclerosis). It is administered by the U.S. Department of Health and Human Services through the Centers for Medicare and Medicaid Services (CMS). Local Social Security Administration offices provide information about the program and take applications for Medicare coverage. Various health insurance companies provide Medicare insurance. These companies contract with CMS to pay Medicare claims.

The New York State Health Insurance Program (NYSHIP) benefits become secondary to benefits covered by Medicare under certain conditions.

Medicare has four parts:

- **Medicare Part A (hospital insurance)** helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care. NYSHIP requires enrollees and their dependents to have Medicare Part A in effect as soon as they become eligible. There is usually no cost for Part A.

- **Medicare Part B (medical insurance)** helps pay for medically necessary doctors' services, outpatient hospital services, home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. NYSHIP requires enrollees and their dependents to have Medicare Part B in effect as soon as they become eligible. A Participating Agency must reimburse enrollees and their dependents for the cost of the Medicare Part B premium charge, including any income related monthly adjustment amount (IRMAA).

- **Medicare Part C (Medicare Advantage)** began in 1998 (as Medicare + Choice), and is designed to provide Medicare beneficiaries with a variety of managed care and private contracting arrangements to enhance their choice of care delivery systems. With a Medicare Advantage Plan, the enrollee assigns Medicare benefits directly to the HMO. All care must be received through that plan's delivery system and there is no coverage for care not received through the HMO. NYSHIP does not offer Medicare Part C Advantage Plans.

- **Medicare Part D (prescription drug coverage)** effective January 1, 2006, is designed to offer coverage for medically necessary drugs through prescription drug plans under contract with CMS or Medicare Advantage prescription drug plans. Although NYSHIP enrollees who are Medicare eligible are eligible to join Part D, there is no NYSHIP requirement to do so and in most cases, NYSHIP enrollees will have better benefits from their NYSHIP prescription drug coverage.

The following section provides **important** information on the relationship of NYSHIP to Medicare and the Participating Agency's responsibilities.

1. The Relationship of NYSHIP to Medicare

Federal law governs when Medicare will provide coverage that is primary to a group health plan such as NYSHIP. A health insurance plan provides "primary coverage" when it is responsible for paying health benefits before any other plan is liable for payment.

Following are the "primary coverage" rules for Medicare eligible persons enrolled in the New York State Health Insurance Program:

a. Active Employees & Dependents of Active Employees (Including Leave Without Pay):

NYSHIP provides primary coverage to active employees and dependents of active employees who are enrolled in the Program regardless of the employee's age or disability based Medicare eligibility status, with the following exceptions:

1) For active employees and dependents of active employees who are eligible for Medicare due to permanent kidney failure (ESRD), NYSHIP provides primary coverage for a three-month waiting period plus the first 30 months of treatment; then Medicare provides primary coverage.

Note: For active employees and dependents of active employees, Medicare waives the three month waiting period if the patient enrolls in a self-dialysis training program during the first three months or receives a kidney transplant within the first three months of being hospitalized for the transplant. In such cases, NYSHIP would only be primary for 30 months before Medicare becomes primary.

2) When active employees and dependents of active employees become eligible for Medicare, they may elect in writing that Medicare will be their primary coverage. However, if an employee makes such an election, coverage under NYSHIP must end for the employee and any covered dependents. Federal Medicare Secondary Payer law prohibits an arrangement where Medicare is primary and a group plan is secondary for an active employee.

Note: An active employee may enroll in Medicare for secondary coverage. Under these circumstances, the active employee is not entitled to receive a Medicare Reimbursement since NYSHIP is providing primary coverage.

b. Active Employees and Domestic Partners of Active Employees:

If a Participating Agency offers domestic partner coverage, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65; however, if the domestic partner becomes Medicare eligible because of a disability, NYSHIP remains primary until the domestic partner reaches age 65 or the enrollee retires.

c. Employees in Non-Active Status and Their Covered Dependents (including Retirees, Vestees, Dependent Survivors, and COBRA):

Medicare coverage is primary for non-active employees and their covered dependents who are 65 years of age or older. Medicare is primary for non-active employees and their covered dependents who are under age 65 and eligible for Medicare due to disability.

d. Primary Coverage for Medicare-Eligible Persons for Services Received Outside the United States:

NYSHIP provides primary coverage for Medicare eligible active and retired enrollees and their Medicare eligible dependents who reside outside the United States, due to the fact that Medicare does not provide benefits for services rendered outside the U.S. Note that Medicare remains primary coverage in Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

A Medicare eligible enrollee or dependent who resides permanently outside the U.S. is not required to enroll in Medicare Parts A & B. NYSHIP would provide primary coverage for such persons in the U.S. in the following circumstances:

Note: The person returns to the United States temporarily (defined as six months or less) and receives medical care. However, should the person return to the United States to reside permanently, NYSHIP would continue to provide primary coverage until the person is eligible for coverage under Medicare.

e. Rehired Retired Employees:

Age 65 or older: When a retiree, age 65 or older, returns to active employment status and meets the eligibility requirements for active employees, the primary health insurer changes from Medicare to NYSHIP regardless of whether NYSHIP coverage is as a retiree or active enrollee. If the enrollee chooses to remain in retirement status on the NYSHIP enrollment file, the Employee Benefits Division will notify the carriers to provide primary benefits. HBAs must notify EBD when the employed retiree begins working and stops working.

Since NYSHIP will pay as primary insurer, Medicare Part B premium reimbursement should be terminated for the enrollee and any enrolled

Medicare eligible dependent. The Mediprime premium rate will also be discontinued for the enrollee as Medicare is no longer the primary insurer. If the employed retiree is not in a benefits eligible position, Medicare remains the primary insurer.

2. NYSHIP Rules for Enrollees Eligible for Primary Medicare Benefits

a. Medicare Enrollment

NYSHIP provides secondary coverage for Medicare eligible enrollees and dependents, whether or not that person is enrolled in Medicare.

It is therefore **very important** that each person (enrollee and dependent) who becomes eligible for Medicare primary coverage enroll in both Medicare Parts A & B. If they fail to enroll in Medicare Parts A & B, their health benefits will be drastically reduced. Social Security will automatically enroll **most** persons, however, it is the enrollee's responsibility to ensure that they are enrolled in Medicare Parts A & B by their first date of eligibility. They should **not** decline Part B if Social Security presents that option.

NYBEAS/Medicare:

If a NYSHIP enrollee or dependent under age 65 is eligible for Medicare primary coverage due to disability, this status **must** be entered into NYBEAS or for agencies without access, contact the Employee Benefits Division. NYBEAS will automatically update Medicare status for non-active employees and their dependents who turn age 65.

b. Medicare Part B Reimbursement

1) When NYSHIP benefits are secondary to Medicare, (whether or not the person is enrolled in Medicare), Section 167a of the New York State Civil Service Law requires each Participating Agency to reimburse Medicare eligible enrollees **and** dependents an amount equal to the current Medicare Part B premium charge, including any income related monthly adjustment amount (IRMAA). (See *PA Memo 07-31*)

(a) Medicare reimbursement is required regardless of the rate of the employer premium contribution. Medicare reimbursement is required in addition to the employer's premium contribution.

(b) The reimbursement is required for all persons covered under NYSHIP who are eligible for Medicare coverage that is primary to NYSHIP, including Dependent Survivors, with the following **exceptions**:

(1) If a Participating Agency has documentation that an employee or dependent who is eligible for Medicare coverage is receiving Medicare reimbursement from

another source (e.g., a public agency or private employer), the Participating Agency is not required to provide a duplicate Medicare reimbursement.

(2) A retiree who returns to employment in a benefits eligible position with the same agency from which they retired is no longer eligible for Medicare reimbursement regardless of whether they continue their coverage as a retiree or active employee. NYSHIP is primary to Medicare while they are in a benefits eligible position.

(3) An active employee or dependent of an active employee who enrolls in Medicare for secondary benefits.

(4) An active employee or dependent of an active employee who elects Medicare as primary coverage. In this case, the person's enrollment in NYSHIP must be terminated and the provisions of Section 167a of the Civil Service Law would not be applicable.

(c) The required reimbursement is the monthly premium charge for coverage under Part B of Medicare, including any income related monthly adjustment amount (IRMAA). Reimbursement for penalty charges for late enrollment is not required. If the enrollee or dependent receives partial reimbursement of the Part B premium from another source, the Participating Agency must ensure that the enrollee or dependent receives the full Medicare Part B reimbursement. It is the agency's choice to supplement the reimbursement or reimburse the full amount.

(d) The Medicare Part B reimbursement must be effective as of the date the employee or dependent first becomes eligible for primary Medicare coverage. If the reimbursement is not started at that time, it must be paid retroactive to the date of first eligibility. However, the Agency should consult with their attorney or accountant regarding any limits on retroactive payments under the provisions of State Finance Law.

(e) The agency has the right to require a refund of Medicare Part B premium amounts that were incorrectly reimbursed to an enrollee when they or the dependent was not eligible for Medicare Part B. The agency should consult with their attorney and/or accountant to determine if there are any applicable state or local laws that regulate the retroactive adjustment.

2) The method of Medicare Part B reimbursement is discretionary for the Participating Agency. Following are examples of acceptable reimbursement methods:

(a) Checks may be issued at periodic intervals. (minimum once a year)

(b) The premium contribution required of enrollees may be reduced by the amount of the reimbursement.

Contact the Employee Benefits Division for assistance or questions regarding appropriate methods of Medicare reimbursement.

c. Medicare Part A

Civil Service Law does not require reimbursement of any portion of premium (if any) for hospitalization benefits under Part A of the Medicare program (there is usually no charge for Medicare Part A).

If the enrollee must pay for Medicare Part A coverage because the enrollee/dependent did not meet the Social Security eligibility requirements for no-cost Part A, the enrollee/dependent must provide a statement from Social Security confirming ineligibility for free Medicare Part A. In this case, there is no need to enroll in Medicare Part A because NYSHIP will continue primary coverage for hospitalization, however, enrollment in Part B is still required.

d. Medicare Part D

There is no NYSHIP requirement for enrollment in Medicare Part D (prescription drug coverage) and therefore no requirement for reimbursement of Medicare Part D premium. The Centers for Medicare and Medicaid Services prohibit an employer from telling retirees that they may not enroll in Medicare Part D.

Medicare Part D and Low Income Subsidy (LIS):

A Participating Agency may elect to offer a no-drug Empire Plan option to enrollees who have been approved for the LIS at a reduced premium. If the Participating Agency elects to offer this option, it will be the agency's responsibility to obtain a copy of the LIS approval from their enrollees and a letter from the enrollee requesting the no-drug Empire Plan option. The Participating Agency must provide this documentation to the Employee Benefits Division which will verify eligibility for the lower cost, no-drug Empire Plan option.

Retirees who do not qualify for the LIS but enroll in Medicare Part D are **not** eligible for the no-drug Empire Plan option.

Retiree Drug Subsidy (RDS):

The New York State Department of Civil Service shall administer the Medicare Part D Drug Subsidy on behalf of each Participating Agency in the New York

State Health Insurance Program (NYSHIP). The Department shall provide to each employer its RDS based upon the actual utilization of each employer's qualified enrollees using the enrollment information provided by the employer. In order to effect this distribution, the Department and the employer must have executed the Medicare Part D Drug Subsidy Agreement Form.

Separation from Service

Termination of Benefits

An employee's coverage in the State Health Insurance Program will end on the last day of the month following the month in which his or her status as an employee ends. However, the Participating Agency may elect administratively or through collective negotiations to end benefits on the last day of the month in which their status as an employee ends. School districts which participate in NYSHIP may elect to provide continuation of coverage during July and August.

At the time an employee separates from the service of a Participating Agency, the employee may be eligible for continuation of coverage under the State Health Insurance Program under either the federal COBRA Continuation of Coverage law (see Section 3.12) or the New York State Continuation of Coverage law (see Section 3.11).

> Note: Do **not** terminate benefits if the employee is eligible to retire or vest for health insurance purposes. (See Section 3.7 for Retirement and 3.14 for Vested Status.)

Employment with another Participating Agency

Enrollees who leave the employment of one Participating Agency to accept employment with another agency which participates in the New York State Health Insurance Program are subject to the waiting periods established by the new Participating Agency.

Death of Enrollee - Survivor Coverage

1. Death of Enrollee with Individual Coverage

   In the event of the death of an employee or retiree enrolled with Individual Coverage, coverage will end on the date of death. A credit will be issued if any premium payments have been submitted for the month(s) after the month in which death occurred.

2. Death of Enrollee with Family Coverage

   a. Extended Benefits Period

      1) In the event of the death of an employee or retiree enrolled with Family Coverage, the coverage of any surviving dependent(s) will be continued for an Extended Benefits Period of three months following the month in which the enrollee's death occurred.

         (a) The extended benefit period continues through the last day of the third month following the month in which the death occurred.

         (b) If the deceased enrollee contributed to the cost of their health insurance coverage, the enrolled dependents will continue to receive coverage without additional charge to the survivors or the agency for three months beyond the month in which the enrollee died.

         (c) Any claims for medical expenses incurred by the dependent survivor(s) during the three-month Extended Benefits Period must be submitted using the health insurance identification number of the deceased employee or retiree.

3. Dependent Survivor Coverage

   a. Eligibility

      1) If the deceased employee or retiree had completed at least **ten (10)** years of active service prior to his or her death, the surviving dependent(s) is eligible to continue Dependent Survivor Coverage under the New York State Health Insurance Program after the three-month Extended Coverage Period.

         Qualifying service includes service with the Participating Agency, the State of New York, or any political subdivisions of New York State eligible to participate in the New York State Health Insurance Program.

         Note: It is recommended that Participating Agencies inform dependents of their options within the required time frames.

2) If a dependent survivor is eligible for coverage in the New York State Health Insurance Program as an employee or retiree of a State Agency, Participating Employer or Participating Agency, he or she may elect to continue NYSHIP coverage through their employer. Such employee or retiree should contact the Health Benefits Administrator of his or her employer.

   If coverage as an active employee ends, the enrollee may re-enroll under Dependent Survivor Coverage. The enrollee is eligible for Dependent Survivor Coverage provided no break in coverage under NYSHIP occurred.

3) If the death of an active employee resulted from a work-incurred injury, the surviving dependent(s) may be eligible to continue Dependent Survivor Coverage under the New York State Health Insurance Program regardless of the length of the deceased employee's service.

   To be eligible for such coverage, the survivor(s) must be entitled to accidental death benefits payable by a retirement system or pension plan administered by New York State or civil division thereof, or be entitled to death benefits provided under the Workers' Compensation Law. If an application has been submitted for such benefits, coverage in NYSHIP may be continued pending a determination by the appropriate retirement system, pension plan or Workers' Compensation insurer provided the same is diligently pursued by the applicant.

4) If eligible under 1), 2), or 3) above:

   (a) The enrolled spouse of a deceased enrollee continues eligibility for coverage for as long as he or she remains unmarried.

   (b) The enrolled dependent children of a deceased enrollee continue eligibility for coverage for as long as they would have qualified as dependents had the enrollee lived. (See Section 2.2)

   Note: The enrollee must have had Family Coverage in effect at the time of death. The survivor cannot add new dependents, except for the following: an unborn child (child of deceased enrollee that has yet to be born); a dependent between the ages of 19-25 who returns to full-time student status, a child in the process of adoption.

5) If *not* eligible for Dependent Survivor Coverage:

   The dependent survivor(s) may be eligible for continuation of coverage through either: the New York State Health Insurance Program under the federal COBRA Continuation of Coverage Law (See COBRA Section 3.12), or through a direct-pay conversion contract with the Empire Plan's hospital or medical program insurer.

b. Cost

1. The cost of Dependent Survivor Coverage is paid entirely by the survivor(s) unless the Participating Agency elects administratively or through collective negotiations to any of the following variations:

(a) If the dependent survivor(s) is eligible for Dependent Survivor Coverage under a.1) above (i.e., the deceased employee or retiree had at least 10 years of service):

(1) The surviving spouse of an active employee may pay 25% of the full cost of Dependent coverage;

or

(2) The surviving spouse of an enrollee who retires after April 1, 1979, with at least ten (10) years of service and who subsequently dies may pay an amount equal to 25% of the full cost of Dependent coverage.

Note: The 25% of Dependent coverage rate under (1) or (2) above will apply whether the surviving spouse is enrolled for Individual or Family coverage.

If there is no surviving spouse or the surviving spouse under (1) or (2) above loses his or her eligibility for coverage as a result of marriage or dies, any dependent children, still eligible, may continue coverage under the New York State Health Insurance Program by paying the full cost of such coverage.

(b) If the dependent survivor(s) is eligible for Dependent Survivor Coverage under a.3) above (i.e., the death of an active employee resulted from a work-incurred injury), the Participating Agency may pay the full cost of coverage for the dependent survivor(s).

c. Dependent Survivor Enrollment

1) An eligible dependent survivor who wishes to continue coverage under the New York State Health Insurance Program must make application to the Participating Agency's Health Benefits Administrator for the coverage within 90 days of the death of the enrollee. The dependent survivor(s) will retain the enrollee's original effective date of coverage.

2) When the dependent survivors are required to pay the cost of coverage and only two dependents are eligible for Dependent Survivor Coverage, two Individual enrollments may be established rather than a Family enrollment.

3) The dependent survivor(s) will be issued new health insurance identification cards with a new alternate identification number.

d. Option Transfer Between Employer-Sponsored Plans

1) Enrollees with Dependent Survivor Coverage have the same rights as other classes or categories of enrollees to transfer between plans sponsored by a Participating Agency which offers enrollees the choice of health insurance coverage in the Empire Plan or in one or more Health Maintenance Organizations. A transfer may be made either during an annual transfer Period or based on a permanent change of residence (see Section 3.3).

2) If a dependent survivor who is enrolled in an alternate health plan sponsored by the Participating Agency subsequently makes an application for coverage in the Empire Plan, such person must have met the criteria of a dependent survivor under the New York State Health Insurance Program and must have had continuous coverage under one of the Employer-Sponsored Plans since the death of the employee or retiree.

If such person described under 2) above is eligible to transfer to Dependent Survivor Coverage under the New York State Health Insurance Program, contact the Employee Benefits Division.

Continuation of Coverage Under the New York State Continuation of Coverage Law

The New York State Insurance Law (Insurance Law, Section 3221) requires that all group insurance policies issued in New York State offer employees and their families the opportunity for a temporary extension of health care at group rates in certain instances where coverage would otherwise end.

The Law affects hospital, surgical and medical expense insurance. Since prescription drug benefits are not defined as "medical expenses" under this Law, they are not included in the NYS Continuation of Coverage benefit package.

If a Participating Agency provides continuation of coverage under the Federal COBRA Law (See Section 3.12), an employee eligible for COBRA Continuation of Coverage is **NOT** eligible for coverage under the NYS Continuation of Coverage Law, with the following exception:

> If an employee's employment is terminated due to "gross misconduct" and coverage is denied under COBRA, he or she is eligible for coverage under the NYS Continuation of Coverage Law.

If a Participating Agency is interested in offering NYS Continuation of Coverage, please contact the Employee Benefits Division.

Continuation of Coverage Under the Federal COBRA Continuation of Coverage Law

The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272, Title XXII), also known as COBRA, requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health insurance at group rates in certain instances where coverage would otherwise end.

Since the administration of COBRA is an employer responsibility and NYSHIP does not know the circumstances surrounding termination of coverage for Participating Agency employees, NYSHIP does not offer detailed technical assistance to agencies on how to administer this federally mandated program. (In order to administer COBRA for State employees and their dependents, the Employee Benefits Division relies on the Commerce Clearing House *COBRA Guide*. Your agency may purchase the *COBRA Guide* or a similar publication to guide your administration. In addition, your agency should consult with a legal adviser to be certain your agency's COBRA administration is in conformance with the law.) **NYSHIP does require, however, that Participating Agencies participating in NYSHIP adopt a policy of "maximum adherence" to COBRA law, except for the exceptions below.** That is, employers must not offer more than the minimum coverage mandated by COBRA law, and must strictly adhere to the deadlines required by COBRA law. As an example, in no instance should COBRA coverage be extended beyond 18 months for employees (29 months if entitled to a disability extension) or 36 months for dependents experiencing events entitling them to 36 months. Enrollees not meeting mandated deadlines for notification of events, payments or COBRA elections should not be granted exceptions, unless they can prove a disability made it impossible to meet deadlines. In short, whatever the law mandates is what will be provided, no more and no less. Lastly, agencies may not pay any part of the COBRA premium for COBRA enrollees, although agencies may waive the 2% administrative charge if they wish.

<u>These exceptions to maximum adherence are permitted</u>:

- While COBRA allows employers to deny coverage when a person is terminated for "gross misconduct," the Participating Agency may allow COBRA in cases of termination for "gross misconduct" because the person is entitled to similar coverage under NYS Continuation of Coverage law, even if the Participating Agency denies COBRA. A Participating Agency may adopt a policy with a clear definition of "gross misconduct."

- COBRA allows the Participating Agency to deny COBRA coverage to persons who acquire other coverage after electing COBRA. However, due to the difficulty of determining whether the other coverage is equivalent to the NYSHIP coverage lost, the Participating Agency may continue COBRA when a person acquires coverage other than Medicare after COBRA election. Whenever a person becomes entitled to Medicare benefits after COBRA election, COBRA **must** be cancelled for that person.

- Participating Agencies must offer COBRA to legally separated spouses who have been removed from NYSHIP coverage prior to a divorce as such coverage would be available under the NYS Continuation of Coverage law. In these cases, the date of

the qualifying event is the date of the legal separation, not the date of the divorce which follows.

- Agencies that have opted to provide domestic partnership benefits to active employees may offer COBRA to domestic partners even though COBRA does not consider domestic partners eligible dependents.

The following pages instruct you on how to begin or terminate COBRA coverage:

COBRA Operations

1. Effective Date

   The date that coverage is lost due to a qualifying event is the date of first eligibility.

2. Qualifying Events

   Under the COBRA law the term "qualifying event" means, with respect to any covered enrollee, any of the following events, which, but for the availability of COBRA coverage, would result in the loss of coverage for a qualified beneficiary.

   a. The death of a covered employee (if enrollee had under 10 years of service).

   b. The termination (other than by reason of such employee's gross misconduct) or reduction of hours, of the covered employee's employment.

   c. The divorce or legal separation of the covered employee from the employee's spouse.

   d. The covered employee becoming entitled to benefits under Medicare.

   e. A dependent child ceasing to be an eligible dependent under the requirements of the plan.

   Note that if a loss of coverage does not occur in the above situations, a qualifying event has not occurred. A qualifying event must occur before COBRA coverage can be provided.

3. COBRA Enrollment Process

   The Participating Agency must provide a COBRA election notice to an enrollee entitled to COBRA within the timeline mandated by law. A qualified employee or dependent who wishes to enroll in COBRA continuation of coverage must notify the Participating Agency of the decision to enroll within the time frame provided by law. If the election is not received within the time limit, NYSHIP rules restrict the employee or dependent from COBRA coverage and the Participating Agency may not enroll the individual.

4. COBRA Premiums

a. The law permits employers to charge COBRA enrollees up to 102% of the premium cost. A Participating Agency will be billed at 100% of the "gross" premium rate for COBRA enrollees. Unlike the "net" premium, the gross premium is not reduced by any dividend or interest. Agencies are not required to charge the enrollee the 2% administrative charge.

In the case of an employee determined to be **disabled** under the Social Security Act, the charge is 150% of the premium cost during the 19th through the 29th month of COBRA coverage. A Participating Agency will be billed at 148% of the gross premium rate for Social Security disabled enrollees during the 19th through the 29th month of COBRA coverage. Agencies are not required to charge the enrollee the 2% administrative charge.

b. Upon receipt of an application for enrollment in COBRA, calculate the amount due to bring the COBRA enrollee's coverage up to date from the date coverage ended under the employer-sponsored plan and bill for the amount. The enrollee has 45 days from the date coverage was elected to pay this retroactive COBRA premium adjustment. The enrollee's subsequent payments may be submitted on a monthly basis or he or she may make larger payments.

5. Period of Coverage

a. Maximum Periods of Coverage

The maximum periods of coverage available under the COBRA continuation of coverage are as follows:

1) Except for circumstances described under (a) and (b) below, an employee whose employment is terminated or whose hours are reduced may have COBRA coverage for up to 18 months (Individual or Family coverage).

(a) When such a person is determined under the Social Security Act to have been disabled at the time of termination of employment or reduction of hours, that person is entitled to a maximum period of 29 months of COBRA coverage. If an enrollee is disabled under Social Security at the time of COBRA election, he must notify the Participating Agency within the first 60 days of COBRA coverage in order to qualify for the 11-month extension for the disabled. If the enrollee becomes disabled under Social Security during COBRA continuation, he must notify the Participating Agency within 60 days of the date of the notice of disability and prior to the end of the 18-month COBRA continuation period in order to qualify for the 11-month extension period.

Prior to the expiration of the enrollee's initial 18 months of COBRA coverage, notify the Employee Benefits Division of the

person's entitlement to extend coverage. The enrollment record will be changed to permit up to 29 months of coverage for the disabled enrollee and others covered under his enrollment.

(b) If a person becomes entitled to Medicare benefits before the expiration of the 18 months (and thus ineligible for COBRA coverage), any dependents who are qualified are entitled to COBRA continuation for a total of 18 months from the date the dependents were initially covered in COBRA through the employee.

Note: A qualified beneficiary is one who was entitled to COBRA continuation as a result of the first qualifying event. "Entitled to Medicare benefits" or "entitled to receive Medicare benefits" means the individual has enrolled in Medicare and claims submitted to Medicare are paid by Medicare. Simple eligibility for Medicare does not disqualify an individual from COBRA eligibility; however, if a Medicare eligible individual does not enroll in Medicare, NYSHIP benefits are reduced by what Medicare would have paid. All persons eligible for COBRA **and** eligible to enroll in Medicare are eligible for the standard Medicare Part B reimbursement because Medicare is primary to COBRA coverage.

2) In the case of any Qualifying Event other than that described in 1) above, the covered dependent is entitled to a maximum period of 36 months of COBRA coverage.

b. Coverage Under Another Group Plan

Coverage under COBRA may be ended on the last day of the month during which the COBRA enrollee or dependent becomes covered under any other group plan with the exception below.

Exception: If the other group plan contains any exclusion or limitation with respect to any pre-existing condition of such beneficiary, the person may continue under COBRA coverage up to the maximum period established under COBRA law (see a. above).

c. Non-payment of Premiums

If a COBRA enrollee fails to make an initial or monthly payment on time, the Participating Agency must allow an additional 30-day grace period. After the grace period, coverage must be cancelled for non-payment of premiums. Coverage ends on the last day of the month for which premiums have been paid. Once coverage has been cancelled, it cannot be reactivated again on COBRA status. A notice of cancellation should be sent to the enrollee indicating the date coverage ends.

6. Changes During the COBRA Continuation of Coverage Period

Coverage and option changes permitted under an employer's basic health plan may also be made by a person who is covered under the COBRA continuation of coverage.

7. Termination of Coverage

a. Maximum Period of Coverage Ends

1) Except in the case of a COBRA enrollee becoming 65 years of age (See 2) below), when the maximum period of COBRA continuation of coverage ends the Health Insurance System will automatically generate a transaction to terminate the COBRA continuation of coverage enrollment record. No agency action is required.

2) COBRA coverage ends for a person who becomes 65 and entitled to receive Medicare benefits on the last day of the month preceding the month in which the birthday occurs.

Note: There is one exception to 2) above. If a person who becomes eligible for Medicare but does not draw a Social Security check and does not enroll in Medicare, that person may continue COBRA continuation of coverage until the maximum period of coverage ends; however, NYSHIP benefits are reduced by what Medicare would have reimbursed.

All persons with COBRA coverage who are eligible to enroll in Medicare must be reimbursed for the cost of the Medicare Part B premium since Medicare is primary to COBRA coverage.

b. Coverage Under Another Group Plan

Agencies are not required to terminate COBRA coverage when an enrollee becomes eligible for health insurance coverage other than Medicare.

Note that a COBRA enrollee who is covered under another group plan may be entitled to continue the COBRA plan coverage due to the other plan's exclusion or limitation with respect to any pre-existing condition of such beneficiary. (See "Period of Coverage") In this case, coverage may continue up to the maximum period permitted under COBRA.

c. When a COBRA enrollee's coverage is terminated due to the maximum period of coverage ending or the individual is covered under another group plan, that individual is entitled to obtain a conversion contract. When a COBRA enrollee's coverage is cancelled for non-payment of premiums, that individual is not entitled to a conversion contract.

Cancellation of Coverage

Voluntary Cancellation of Coverage

1. An enrollee may cancel his or her coverage in the New York State Health Insurance Program at any time.

2. The enrollee's coverage will end on the last day of the month in which he or she requests cancellation of coverage.

   Note: Agencies that offer pre-tax contributions should consult with an attorney or financial advisor regarding IRS regulations when canceling coverage.

Cancellation of Coverage for Failure to Pay Premiums

1. If an enrollee who is required to remit premium payments fails to do so, his or her coverage in the New York State Health Insurance Program must be cancelled at the end of the month for which payment has been remitted.

   For the purpose of this paragraph, the following **are required** to remit premium payments:

   a. Persons on authorized leave without pay, seasonal layoff or on a Civil Service preferred list for reinstatement;

   b. Retirees who pay the employee-share of the premiums directly to their former employers;

   c. Vestees;

   d. Dependent Survivors;

   e. Persons who have coverage under the federal COBRA Continuation of Coverage law or under the New York State Continuation of Coverage law.

Important Consequences of Cancellation of Coverage, Either Voluntary or for Non-Payment of Premium

1. An enrollee who voluntarily cancels coverage or whose coverage is cancelled for non-payment of premiums has no guaranteed right to obtain a direct pay policy from the insurance carriers. Cancellation of coverage is **not** a COBRA qualifying event.

2. Enrollees on authorized leave without pay, seasonal layoff or on a Civil Service preferred list for reinstatement may be subject to waiting periods if they wish to reenroll at a later date (See Section 3.4). Such cancellation may also jeopardize an employee's eligibility to continue coverage in retirement (See Section 3.7).

3. Retirees whose coverage is cancelled either voluntarily or for non-payment are subject to waiting periods if they wish to reenroll at a later date (See Section 2.7, 3.d.2).

4. Vestees, Dependent Survivors, and persons who have coverage under the federal COBRA Continuation of Coverage law or the New York State Continuation of Coverage law are **not** permitted to reenroll after cancellation of their coverage, either on a voluntary basis or for non-payment of premium.

   Vestees whose coverage is terminated also lose eligibility to have coverage in retirement.

Vested Status

Eligibility While in Vested Status

1. An enrolled employee who terminates employment before retirement age is eligible to continue coverage under NYSHIP as a vestee if the enrollee:

   a. is a member of a retirement system administered by and operated by the State of New York or a civil division thereof and has satisfied the minimum requirements established by the retirement system for vesting the right to a retirement allowance;

   and

   b. is a member of a class or category for which the employing agency either is required to provide coverage in retirement or has elected administratively or through collective negotiations to provide such coverage;

   and

   c. has met the employer's minimum service requirement, other than age, for continuation of health insurance coverage into retirement;

   and

   d. has terminated employment within five years of the date on which he or she is entitled to receive a retirement allowance, **if the employing agency has established administratively or through collective negotiations this additional requirement**.

Eligibility for Coverage as a Retiree

1. To retain eligibility for coverage as a retiree, a vestee must continue coverage under NYSHIP as an enrollee or a dependent of an enrollee while in vested status with **no lapse in NYSHIP coverage**. There are three ways to continue coverage while in vested status:

   a. By paying the NYSHIP premium to the Participating Agency;

   b. By maintaining NYSHIP coverage as a dependent (e.g., through spouse or domestic partner);

   c. By maintaining NYSHIP coverage as an active employee through another Participating Agency or Participating Employer.

   Note: A NYSHIP enrollee can maintain enrollment through different Participating Agencies as long as there is no lapse in coverage.

2. When an employee has established eligibility to continue health insurance coverage as a vestee through one Participating Agency, that eligibility is not impaired by subsequent employment and/or enrollment through another Participating Agency, except when the employee establishes eligibility for coverage under NYSHIP as a vestee or retiree through a second agency. In this situation, the first Participating Agency is released from its obligation to provide the vestee with coverage in retirement.

   Important Note: A vestee whose coverage lapses will **not** be permitted to reinstate coverage, either during vested status or after retirement.

Cost of Coverage While in Vested Status

1. Eligible employees who continue coverage as enrollees in NYSHIP during vested status must pay the full monthly premium for their coverage for the following period of time:

   a. The full share payment period begins with the month following the end of the month in which a separated employee's coverage would normally end. This may either be the first month or the second month following the month in which the employee terminates employment (See Section 3.9).

      Example: A Participating Agency's policy is to provide employees who terminate employment with coverage through the end of the month following the month in which the termination occurs. An employee, eligible to continue coverage in vested status, terminates employment July 15. The full-share payment period begins September 1st.

   b. The full share payment period continues until the end of the month in which the vestee becomes entitled to a pension, whether or not he or she actually begins receiving the pension. After that date, the enrollee is considered retired for health insurance purposes and only responsible for the retiree share of NYSHIP premium payments, if any.

2. All required payments by the vestee must be made to his or her former employing agency. If an enrollee in vested status fails to remit the required health insurance payments, their coverage must be cancelled.

   When a retiree starts collecting their pension, they may be eligible to have the required premium deducted from their pension. The retiree should contact the Health Benefits Administrator at the Participating Agency they retired from (See Section 3.7).

Comments and Recommendations

If you have any comments, recommendations, or corrections to the *Manual*, please write them below or attach your comments to this page and fax it to: (518) 474-3744

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This recommendation is related to Section: _____

My contact information is:

Name:_____

Title:_____

Agency Name and Code:_____

Phone Number:_____

E-Mail:_____

On behalf of the Employee Benefits Division at the New York State Department of Civil Service, we thank you for your time.