General Information Book

For the BCI Unit of the New York State Police
represented by the **Police Investigators Association**
enrolled in NYSHIP-approved
Health Maintenance Organizations
and for their enrolled dependents
and for COBRA enrollees with their benefits

April 1, 2003

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

New York State Health Insurance Program (NYSHIP) General Information Book

NYSHIP overview; your options 1
Eligibility 4
Enrollment 8
Coverage: Individual or Family.....9
ID cards.....11
Premium costs.....12
Changes in status, leaves 15
Retirement coverage 18
Vestee coverage 25
Survivor coverage.....25
COBRA:
Continuation of coverage 27
Direct-pay contract.....30
Medicare:
When you must enroll 30
Keep your coverage up to date 34
Web site information.....35

Telephone Numbers .....Inside back cover

New York State Health Insurance Program General Information for the Bureau of Criminal Investigation (BCI Unit) of the New York State Police represented by the Police Investigators Association (PIA) and their Dependents Enrolled in HMOs *and for COBRA Enrollees with their benefits*

This book explains your rights and your responsibilities as an enrollee in the New York State Health Insurance Program (NYSHIP). Please review this information and share it with members of your family.

The policies and benefits described in this book are established by the State of New York through negotiations with State employee unions and administratively for non-represented groups. Policies and benefits may also be affected by federal and state legislation and court decisions. The Department of Civil Service, which administers NYSHIP, makes policy decisions and interprets rules and laws affecting these provisions. Therefore, the policies and benefits described in this book are subject to change as a result of those processes. You will be notified of changes by mailings to your home.

About This Book

This **New York State Health Insurance Program (NYSHIP) General Information Book** combines previous documents. It replaces the April 1, 1999 NYSHIP General Information Book for the BCI Unit of the New York State Police represented by the Police Investigators Association (PIA) and later NYSHIP Changes included in NYSHIP Health Maintenance Organizations Reports.

Be sure you are eligible; receipt of this book does not guarantee you are eligible or enrolled for coverage.

Be sure you have the right book. This book is for PIA-represented employees who are in active service and their dependents and COBRA enrollees, covered through NYSHIP HMOs.

Save this book and all subsequent NYSHIP HMO Reports. New books are not issued every year. Supplements will be sent to you if benefits change. It is important that you read and keep this book and future NYSHIP HMO Reports/NYSHIP Changes that update this book and inform you of important changes to your NYSHIP coverage.

If You Need Assistance

If you want information on your enrollment, eligibility or any other aspect of the New York State Health Insurance Program, **contact your agency Health Benefits Administrator (HBA), usually in the Human Resources (Personnel) Office.** See *"Important Telephone Numbers"* on the inside back cover of this book. COBRA enrollees: Contact the Employee Benefits Division (see inside back cover).

You are responsible for letting your agency know of any changes (such as an address change) that may affect your NYSHIP-HMO coverage. See *"Keeping Your Coverage Up to Date"* on page 34. COBRA enrollees: Contact the Employee Benefits Division.

You may also visit our Web site at *www.cs.state.ny.us* (Click on Employee Benefits).

For questions on specific benefits or HMO services, call your HMO. Please have your health insurance identification number ready when you call.

April 1, 2003

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Department of Civil Service
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CONTENTS
NYSHIP General Information Book

Overview of NYSHIP, 1

Your Options Under NYSHIP, 1
- The Empire Plan, 1
- A Health Maintenance Organization, 2
- Annual Option Transfer Period, 2
- Changing Options outside the Option Transfer Period, 2
- Your dependents' option, 3

Who is Eligible?, 4
- You, the enrollee, 4
- Your dependents, 4
- Proof of eligibility, 7

Enrollment, 8
- You must apply, 8
- When coverage begins, 8
- How to cancel enrollment, 8
- When coverage ends, 8
- Certificate of Coverage dates, 9
- Re-enrolling a dependent, 9

Coverage: Individual or Family, 9
- Individual Coverage, 9
- Family Coverage, 9
- Changing from Individual to Family coverage, 9
- When your Family coverage begins, 9
- Coverage for newborns, 10
- Changing from Family to Individual coverage, 11

Identification Cards, 11

Costs, Pre-Tax Program and What Your Paycheck Stub Shows, 12
- Your share of the premium, 12
- Pre-Tax Contribution Program (PTCP), 12
- Changes permitted only after certain events, 13
- Another money-saving program, 14
- What your paycheck shows, 14
- Waiver of premium, 14

How Changes in Your Status Affect Coverage, 15
- Leave without pay, 15
- Family and Medical Leave Act, 16
- Military leave, 16
- Suspending or canceling coverage while off the payroll, 16
- Health insurance while you're on Workers' Compensation, 17
- Layoff and Preferred List, 17

Continuing Coverage When You Retire, 18
- Eligibility for retiree coverage, 18
- Disability retirement, 19
- Sick leave credits, 20
- Dual Annuitant Sick Leave Credit, 20
- Deferred Coverage, 23

Health Insurance as a Vestee, 25

Coverage for Your Dependent Survivors, 25

COBRA: Continuation of Coverage, 27
- 60-day deadline to apply in writing, 28
- Costs under COBRA, 29

Changing from NYSHIP to a Direct-Pay Conversion Contract, 30

Medicare: When You Must Enroll and Coordinating With NYSHIP, 30
- Medicare: A federal program, 30
- NYSHIP is primary for most active State employees, 30
- Medicare is primary for domestic partners at 65 and end stage renal disease, 31
- You must have Medicare in effect when first eligible for Medicare coverage that is primary to NYSHIP, 31
- When you are no longer an "active employee," 32
- When to enroll in Medicare, 32
- Planning to Retire: Avoid a gap in coverage, 32
- How to enroll, 33
- Medicare premium reimbursement, 33
- Re-employment, 33

Keeping Your Coverage Up to Date, 34

Visit us on the Web, 35

Telephone Numbers, Inside back cover

Overview of the New York State Health Insurance Program (NYSHIP)

Valuable benefits, choice of plans

You are among the 1.1 million enrollees and dependents who make the New York State Health Insurance Program (NYSHIP) one of the largest group health insurance programs in the United States. NYSHIP provides valuable medical benefits for you and your eligible dependents through two different options: The **Empire Plan**, a unique State plan with some managed care features, or health care from a participating **Health Maintenance Organization (HMO)** in your area. Both options provide benefits for hospital care, medical/surgical care, mental health and substance abuse treatment and prescription drugs.

Coverage is not automatic

If you are eligible for NYSHIP, you may enroll in the option of your choice. But enrollment is not automatic; you must file an enrollment form with your agency Health Benefits Administrator.

New York State pays most of your premium

You may choose Individual coverage for yourself only or Family coverage for yourself and your eligible dependents. For most enrollees, New York State pays most of the premium. You pay the balance, which is deducted from your paychecks.

Other savings

Under the Pre-Tax Contribution Program (PTCP), discussed on page 12, your share of the premium is deducted from your pre-tax salary, which may mean lower taxes for you.

Identification cards

Your HMO will issue the identification card(s) for you and your enrolled dependents to present to providers and pharmacies when receiving services.

After NYSHIP eligibility ends

Under certain circumstances, you may be able to continue your NYSHIP coverage when your payroll status changes (for example, if you are on leave without pay or laid off). Many retirees, vestees, and dependent survivors are also eligible to continue NYSHIP coverage. If your eligibility for NYSHIP coverage ends, under certain circumstances you may be able to continue benefits for a specified period under a federal continuation law (COBRA) or by converting to a direct-pay contract with your HMO.

Your Health Benefits Administrator

The Employee Benefits Division in the Department of Civil Service works with the Health Benefits Administrator in each agency to process transactions and help you with your health insurance questions. You are responsible for notifying your agency Health Benefits Administrator of any changes that might affect your enrollment. See *"Important Telephone Numbers"* on the inside back cover.

The above is a quick overview. For more information, read the following pages carefully.

Your Options Under NYSHIP

The options

To enroll for health insurance coverage, you will need to decide which option you want: the Empire Plan or a Health Maintenance Organization (HMO) that has been approved for participation in NYSHIP in the geographic area where you live or work. However, HMOs approved for participation in NYSHIP may not be available in all areas.

The benefits provided by the Empire Plan and the HMOs differ. Be sure to weigh your needs and choose the option that provides the most suitable coverage.

The Empire Plan

The Empire Plan is a health insurance program designed exclusively for New York's public employees. The Empire Plan pays for covered hospital services, physicians' bills, prescription drugs and other covered medical expenses.

What the Empire Plan provides

The Empire Plan provides to enrollees and eligible dependents:

- Hospital and related expense coverage through Empire Blue Cross Blue Shield, a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans (copayments apply for certain outpatient hospital services);
- Medical/surgical benefits through United HealthCare Insurance Company of New York (United HealthCare) for a modest copayment for certain services when you use participating providers;
- Basic Medical coverage through United HealthCare subject to deductible and coinsurance for certain services when you receive medical/surgical coverage from non-participating providers;
- Home Care Advocacy Program and Managed Physical Medicine Program through United HealthCare;
- Mental Health and Substance Abuse Program through Group Health Incorporated (GHI)/ValueOptions;
- Prescription drug coverage through CIGNA/Express Scripts; and
- Benefits Management Program through Empire Blue Cross Blue Shield for prior authorization of hospital and skilled nursing facility admissions and through United HealthCare for Prospective Procedure Review for Magnetic Resonance Imaging.

A Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) provides coverage for health care services which are fully covered after you pay any applicable copayments and coinsurance. To enroll in an HMO participating in NYSHIP, you must live or work within that HMO's NYSHIP geographic service area. Except for emergency services, you and your enrolled dependents must receive services from your HMO's physicians or at health centers or hospitals affiliated with the HMO unless you have made other arrangements with your HMO.

What HMOs provide

Each HMO provides a specific package of benefits. Each provides to you and your eligible dependents:

- Hospitalization and related expense coverage;
- Medical/surgical care, including coverage for mental health and substance abuse. Some HMOs provide services at group medical facilities; others do so through contracts with independent physicians; and
- Prescription drug coverage.

Annual Option Transfer Period

During the annual Option Transfer Period, usually in November, you may change your health insurance option for any reason. You may change from an HMO to the Empire Plan, or from the Empire Plan to an HMO or from one HMO to another HMO in your area.

Each year you will be notified of the Option Transfer Period dates through your agency Health Benefits Administrator or a mailing to your home. Option transfer information is also available on the Internet at www.cs.state.ny.us. Check deadlines and consider your options carefully.

To change options during the Option Transfer Period, see your agency Health Benefits Administrator. Check the rate sheet mailed to your home for the exact starting date for your new coverage.

Changing options *outside* the Option Transfer Period

You may change options outside the designated Option Transfer Period **only** under the following circumstances:

- You are enrolled in an HMO and you move permanently out of your HMO's service area. You **must** change options in order to keep your NYSHIP coverage. You may change to an HMO approved for participation in NYSHIP in your new area, or you may change to the Empire Plan.

- You move to a new permanent address and your new home area is served by an approved HMO that did not serve your previous home area. You may change to the new HMO regardless of what option you were in before you moved.
- You have a job change and want to change to an HMO that was not available where you previously lived or worked.
- You have a job change out of the NYSHIP service area of the HMO in which you were enrolled.
- You return to the State payroll after military leave.
- You return to the State payroll after a break in service, if you were ineligible to continue enrollment during the break.
- You return to the State payroll after going on leave without pay. If you canceled your health insurance and missed an Option Transfer Period during the leave, you have 28 days after your return to the payroll to change your option.
- You are assigned a new State service anniversary date following a break in service.
- You retire and do not live in the HMO's service area but are enrolled in the HMO because you worked in the HMO's service area.
- You are an HMO enrollee covered under a prescription drug program provided by an Employee Benefit Fund and you lose eligibility for that coverage because of a change in negotiating unit. You may change options when the negotiating unit change takes place.
- Your dependent experiences an unforeseen change in permanent residence and is no longer in your HMO's service area. (Note: A student attending college outside your HMO's service area is not considered to have made a change in permanent residence.)

Your dependents' option

You and your dependents will have the same option. You, as the enrollee, will determine their option. There is one exception: A spouse or dependent child who continues health insurance coverage under the federal COBRA law may elect an option different from yours during the Option Transfer Period, or when moving under the circumstances described above. (See *"COBRA: Continuation of Coverage"* on page 27.)

Examples of option transfer requests that are turned down

Q. My doctor no longer participates in the option I selected. May I change to another option?

A. Not until the annual Option Transfer Period.

Q. I'm going to retire next month. May I change options?

A. Not until the annual Option Transfer Period, unless you meet one of the specific conditions listed above.

Q. My wife needs an operation right away. We would like a different group of doctors to take care of her. May I change options so her surgery will be covered?

A. Not until the annual Option Transfer Period, unless you meet one of the specific conditions listed above.

Q. My child has just been diagnosed with a chronic condition requiring an expensive brand-name drug. Since I will be filling prescriptions for this medicine regularly for a long time, my out-of-pocket costs will be high. May I change to another option where my cost for this prescription will be lower?

A. Not until the annual Option Transfer Period.

Consider carefully

Be sure you understand how your benefits will be affected by changing options. You are choosing a benefit package for yourself and your dependents for the program year, January through December. By changing options, you could be getting substantially different coverage.

Who is Eligible?

This section explains eligibility requirements under NYSHIP for you (the enrollee) and your dependents.

You, the enrollee

To be eligible for coverage, you must be appointed or elected to a position in State service and:

1. Be expected to work at least six biweekly payroll periods.

   and

2. Work at least half-time on a regular schedule. However, if you are working at a public educational institution (such as a public school, college or university) while pursuing a degree there, you must work full-time.

   and

3. Be on the payroll at the time you enroll. If you begin work, then take an unpaid leave of absence, you are not eligible until you return to the payroll and complete a total of 42 days on the payroll, including days worked before your leave began.

   and

4. Not already be enrolled in NYSHIP as an employee. If you are covered under the program **as a dependent** of your spouse, and you are eligible for your own coverage in NYSHIP, you and your spouse may choose one Family coverage or you may each have Individual coverage or you may have one Family coverage and one Individual coverage.

Per Diem/Hourly employees may be eligible for coverage. Contact your agency Health Benefits Administrator for information.

Your dependents

The following dependents are eligible for NYSHIP coverage:

1. Your spouse

Your spouse, including a legally separated spouse, is eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage. If your marriage ends, you must notify your agency Health Benefits Administrator and end coverage for your spouse effective the date the marriage ends. Your spouse may be able to continue coverage under COBRA. (See *"COBRA: Continuation of Coverage"* on page 27.)

Or your domestic partner

You may cover your same or opposite sex domestic partner as your dependent under NYSHIP. A domestic partnership, for eligibility under NYSHIP, is one in which you and your partner are 18 years of age or older, unmarried and not related in a way that would bar marriage, living together, involved in a lifetime relationship and financially interdependent. To enroll a domestic partner, you must have been in the partnership for one year and be able to provide proof of residency and financial interdependence. Agency Health Benefits Administrators have complete information on eligibility, enrollment procedures and coverage dates.

To cover your domestic partner's child, the standard NYSHIP provisions for adding a dependent apply. (See *"Other children"* in paragraph 2 below. Note that waiting periods may apply when you enroll a dependent more than seven days after eligibility begins.)

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health insurance benefits is treated as income for tax purposes. Under the Pre-Tax Contribution Program, the employee's extra cost for domestic partner coverage cannot be paid with pre-tax dollars. Ask your tax consultant how enrolling your domestic partner will affect your taxes.

If the partnership ends, you must notify your agency Health Benefits Administrator and end coverage for the domestic partner. Your domestic partner may be able to continue coverage under COBRA. (See *"COBRA: Continuation of Coverage"* on page 27.)

There will be a two-year waiting period from the termination date of your previous partner's coverage before you may again enroll a domestic partner.

Employees who fraudulently enroll a domestic partner are held financially and legally responsible for any benefits paid and are subject to disciplinary action. Such employees will forfeit future coverage.

If you die, your surviving domestic partner may be eligible to continue in NYSHIP; however, coverage will end if he or she marries or acquires a domestic partner. (If your surviving *spouse* acquires a domestic partner and your spouse is otherwise eligible, your spouse may continue coverage in NYSHIP, but may not cover the domestic partner.) See *"Coverage for Your Dependent Survivors"* on page 25 to determine whether your partner is eligible.

Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes Medicare-eligible due to disability, NYSHIP is primary.

In other respects, throughout the General Information Book, coverage for a domestic partner and spouse is the same.

2. Your child under age 19 *(or 21 if enrolled in the Empire Plan)*

If you are enrolled in an HMO, eligibility for your children ends at age 19.

If you enroll in the Empire Plan, your children under age 21 are eligible for coverage as described below, while you are an active State employee.

Your unmarried children under 19 years of age *(or 21 if enrolled in the Empire Plan)* are eligible. This includes your natural children, legally adopted children, including children in a waiting period prior to finalization of adoption, and your dependent stepchildren. Other children who reside permanently with you in your household who are chiefly dependent on you and for whom you have assumed legal responsibility in place of the parent also are eligible; you must verify eligibility and provide documentation upon enrollment and every two years thereafter.

3. Your child age 19 or over *(or 21 if enrolled in the Empire Plan)* who is a full-time student

Your unmarried dependent children who are age 19 or over *(or 21 if enrolled in the Empire Plan)* but under age 25 are eligible if they are **full-time** students at an accredited secondary or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage. They continue to be eligible until the earlier of the following dates:

- The end of the third month following the month in which they complete course requirements for graduation; or
- They reach age 25.

For children other than your natural children, legally adopted children or dependent stepchildren, support by you as described in paragraph 2 must have commenced before the child reached age 19 *(or 21 if enrolled in the Empire Plan)*.

If your child reaches age 19 *(or 21 if enrolled in the Empire Plan)* during a school vacation period, coverage will continue, as long as the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution and plans to resume classes on a full-time basis at the end of the vacation period. Proof of enrollment may be required.

Students who want to continue health insurance coverage during the summer must have been enrolled in the previous spring semester and must be enrolled as full-time students for the fall semester.

Note: NYSHIP rules for dependent students continuing coverage during summer vacation between the spring and fall semesters also apply to dependent students continuing coverage during a winter vacation between the fall and spring semesters.

Spring student, enrolled for fall A dependent child who is a full-time student in the spring semester and enrolled as a full-time student for the fall, and attends school in the fall, continues coverage under the parent's policy during the summer.

Spring student, enrolled for fall, but does not attend in fall When a dependent child who was enrolled in the spring semester and for the following fall semester will not be returning to school full-time for the fall semester, coverage under the parent's policy will terminate on the last day of the month in which the enrollee notifies the Employee Benefits Division that the student will not be continuing as a full-time student. The child must apply to the Employee Benefits Division for COBRA coverage within 60 days of the NYSHIP termination date.

If the enrollee notifies the Employee Benefits Division after classes start in the fall, the date of the qualifying event for COBRA coverage will be the first day of classes of the fall semester; proof of the first day of classes may be requested. The child must apply for COBRA coverage within 60 days of the qualifying event.

Students who were enrolled for 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 and the child will not be eligible for COBRA coverage.

Spring student, not enrolled for fall 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 semester, 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. The child must apply for COBRA coverage within 60 days of the NYSHIP termination date.

Spring student, seeking fall admission If a dependent child who was a full-time student in the spring semester is not enrolled for the fall semester but is seeking admission to a school over the summer, the child must enroll for COBRA coverage within 60 days of the last day of the month in which the child was a full-time student attending classes. If the child then does enroll as a full-time student for the fall semester, once the student actually begins attending school full-time in the fall semester, coverage as a dependent student under the parent's policy will be reinstated retroactively and COBRA payments will be refunded. Contact your agency Health Benefits Administrator to re-enroll your child on your policy as a dependent student. Contact the Employee Benefits Division to cancel COBRA enrollment and request a refund of any premiums already paid.

Entering school When an enrollee with Family coverage applies for dependent student coverage for a dependent child who is not currently a student, coverage will begin on the first day of the month in which attendance in class actually starts. When an enrollee with Individual coverage applies for a change to Family coverage in order to cover a dependent student who is entering school, the date coverage begins depends on the enrollee's promptness in applying. (See *"When your Family coverage begins"* on pages 9 and 10.)

Withdrawing from school When a dependent student withdraws from school after classes have begun for the semester, coverage will end on the last day of the month in which the dependent attended classes as a full-time student. The child must apply for COBRA coverage within 60 days of the NYSHIP termination date.

Reduced course load If a dependent child who is enrolled as a full-time student voluntarily drops a course and becomes a part-time student, coverage will end on the last day of the month in which the dependent child was considered a full-time student. The child must apply for COBRA coverage within 60 days of the NYSHIP termination date. If a dependent child becomes a part-time student because the school has canceled a course and the dependent child cannot register in another course to continue full-time status, coverage as a dependent student will continue through that semester as if the dependent child was a full-time student.

Partially disabled students

A partially disabled dependent student between the ages of 19 *(or 21 if enrolled in the Empire Plan)* and 25 taking a reduced course load that is the maximum for that student's capability is eligible; you must provide medical documentation.

Medical leave for students age 19 or over *(or 21 if enrolled in the Empire Plan)*

If your child is granted a medical leave by the school, health insurance coverage will continue for a maximum of one year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester. You must be able to provide written documentation from the school and/or doctor.

Military service

For purposes of eligibility for health insurance coverage as a student dependent, you may deduct from your dependent's age up to four years for service in a branch of the U.S. Military. You must be able to provide written documentation from the U.S. Military.

4. Certain students completing graduation requirements

Your unmarried dependent children who are age 19 or over *(or 21 if enrolled in the Empire Plan)* but under age 25 who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:

A. Otherwise qualify;

and

B. Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed;

and

C. Be able to provide a statement from their school or college administrator which verifies the student's status. They continue to be entitled to benefits for up to three months following the end of the month in which they complete course requirements for graduation. At the end of the three months, the graduated student will have 60 days to apply to the Employee Benefits Division for COBRA continuation of coverage. A dependent child may be granted a second semester of coverage during part-time attendance if there are unusual, extenuating circumstances, which, through no fault of the student, prevent that student's timely graduation. Requests for this continued coverage must be submitted in writing to the Employee Benefits Division.

5. Disabled dependents

Your unmarried dependent children age 19 or over *(or 21 if enrolled in the Empire Plan)* who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for health insurance are eligible. For example, if your child becomes disabled at age 19 or older *(or 21 if enrolled in the Empire Plan)* while covered as a full-time dependent student, the child may qualify to continue coverage as a disabled dependent.

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

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

If your child who is age 19 or over *(or 21 if enrolled in the Empire Plan)* but under age 25 is covered as a full-time student, and is disabled or becomes disabled while a full-time student, contact your agency Health Benefits Administrator as soon as possible to file a Disability Form PS-451.

Proof of eligibility

All new enrollees and dependents must provide proof of eligibility to enroll in NYSHIP. Your application to enroll or to add a dependent to your coverage will not be processed unless accompanied by satisfactory documentation. Providing false or misleading information about eligibility for coverage or benefits is considered fraud.

Under certain circumstances, you may be able to re-enroll a dependent who regains eligibility after a period of ineligibility. Please read *"Re-enrolling a dependent"* on page 9.

Questions?

Active employees: If you have any questions concerning eligibility, please contact your agency Health Benefits Administrator. COBRA enrollees: Contact the Employee Benefits Division.

Enrollment

Enrollment is not automatic

If you are eligible for NYSHIP and you decide you want to be covered, you must sign up for coverage and select either the Empire Plan or a Health Maintenance Organization (HMO). You will not be covered automatically. At the time you enroll, you must also decide whether you want to participate in the Pre-Tax Contribution Program. (See *"Pre-Tax Contribution Program (PTCP)"* on page 12.)

You must apply

To enroll for coverage, you must file Form PS-404 with your agency Health Benefits Administrator. If you choose an HMO, you must also file an HMO Enrollment Form for NYS Employees, which your agency will send to the HMO.

If you or a dependent whom you wish to enroll is covered by another group insurance plan, you must complete a Coordination of Benefits Form PS-600.

When coverage begins

If you are a new employee eligible for coverage, and you enroll within 42 days of becoming eligible, your coverage will begin on your 43rd day of eligible employment.

Regular enrollment: 42-day waiting period

Newly eligible employees have the same 42-day waiting period. "Newly eligible employees" are employees who are not eligible for coverage under NYSHIP when they are hired, but become eligible later. (For example, their work schedule increases from 30 percent to 50 percent.) If you are a newly eligible employee and you enroll within 42 days of the day you became eligible, your coverage will begin on your 43rd day of eligible employment.

New or newly eligible employees who do not enroll within 42 days of becoming eligible are considered late enrollees. Late enrollees have a longer waiting period.

Late enrollment: You wait longer

Coverage for late enrollees begins on the first day of the fifth payroll period after they apply for coverage. For example: If you enroll on the first day of a payroll period, you must wait four full payroll periods, and your coverage will begin on the first day of the fifth payroll period.

If you enroll in the middle of a payroll period, your waiting period will include the payroll period you are in when you enroll plus four more complete payroll periods.

When Coverage Begins

If you enroll within 42 days of becoming eligible, your coverage begins on the 43rd day of eligible employment

If you enroll later than the 42nd day following eligibility, your coverage begins on the first day of the fifth payroll period after you apply for coverage.

No coverage during waiting period

Medical expenses incurred or services rendered during your waiting period will not be covered. Be sure to keep any other insurance you may have, if possible, to cover medical or hospitalization expenses until your NYSHIP coverage becomes effective.

How to cancel enrollment

To cancel your enrollment in NYSHIP, see your agency Health Benefits Administrator.

Note: If you are enrolled in the Pre-Tax Contribution Program, you may not change your health insurance deduction during the tax year unless you meet one of the qualifying events or significant changes. (See *"Changes permitted only after certain events"* on page 13.)

When coverage ends

Coverage ends 28 days after the last day of the last payroll period for which you were paid.

Certificate of Coverage dates

If you or your dependent loses NYSHIP HMO coverage, your HMO is required under federal law to mail you a Certificate of Coverage. This certificate will state the beginning and ending dates of your or your dependent's NYSHIP HMO coverage period. You will receive a certificate if you change your health insurance option under NYSHIP, if your COBRA coverage ends, if your insurance is canceled for non-payment during leave without pay, or if you lose your coverage for any other reason. If you lose your health insurance coverage, you may need the Certificate of Coverage to reduce the length of a pre-existing condition exclusion in a new plan outside NYSHIP.

Re-enrolling a dependent

Dependents who lose eligibility because of marriage, loss of student status, or loss of disabled dependent status may be eligible to reenter NYSHIP if they subsequently become divorced, widowed or re-enroll in school, provided they are otherwise eligible. Unmarried disabled dependents may also reenter NYSHIP if they have a relapse of the same disability which qualified them as disabled dependents while they were in NYSHIP and which again renders them incapable of self-support. (COBRA enrollees: A dependent child who becomes disabled during COBRA status is not eligible to re-enroll in NYSHIP as a disabled dependent under the parent's policy.) The only circumstance in which a dependent survivor may reenter NYSHIP after losing eligibility due to marriage is annulment of the marriage. To re-enroll, you must be able to provide documentation.

Coverage: Individual or Family

Two types of coverage

Two types of coverage are available to you under NYSHIP:

- **Individual Coverage** provides benefits for you only. It does not cover your dependents even if they are eligible for coverage.
- **Family Coverage** provides benefits for you and your eligible, enrolled dependents. To enroll yourself and your dependents in Family coverage, you must provide each person's date of birth, Social Security number (if one is assigned) and other information to NYSHIP through your agency Health Benefits Administrator.

If you and your spouse are each eligible for your own coverage in NYSHIP:

- You may have one Family coverage, or
- You may each have Individual coverage, or
- You may have one Family coverage and one Individual coverage.

Note: Your Pre-Tax Contribution Program (PTCP) enrollment status may limit changes in your health insurance deduction. Please review the *"Pre-Tax Contribution Program (PTCP)"* information on page 12 if you are considering a change in your type of coverage.

Changing from Individual to Family coverage

If you qualify for a change from Individual to Family coverage and you want Family coverage, contact your agency Health Benefits Administrator. You may request this change at any time you qualify; you do not need to wait until the Option Transfer Period.

When your Family coverage begins

The date your Family coverage begins will depend on your reason for changing and your **promptness** in applying. You can avoid a waiting period by applying promptly.

If you and a dependent each have Individual coverage in NYSHIP and you change to one Family coverage, there is no waiting period.

If you change to Family coverage as the result of one of the following events:

- You acquire a new dependent (for example, you marry). Note: The time frame for covering newborns is different. See *"Coverage for Newborns: You have 30 days"* below.
- Your spouse's other health insurance coverage ends.
- You return to the State payroll after military leave and you want to cover dependents acquired during your leave.

*Then, your new coverage begins according to **when** you apply:*

- If you apply **not more than seven days after** the event, your Family coverage will be effective on the date the dependent(s) was first eligible.
- If you apply **more than seven days but less than 29 days after** the event, there will be a waiting period. Your Family coverage will become effective on the day you apply if you apply on the first day of a payroll period. Otherwise, it will begin on the first day of the next payroll period.
- If you apply **more than 28 days after** the event, there will be a longer waiting period. Your Family coverage will become effective on the first day of the fifth payroll period following the payroll period in which you apply.

No coverage during waiting period

Services received or expenses incurred by your dependent(s) during this waiting period will not be covered.

Coverage for newborns: You have 30 days

If you want to change from Individual coverage to Family coverage to cover a newborn child from the date of birth, you have 30 days from the child's birth to request this change.

If you are adopting a newborn, you must establish legal guardianship as of the date of birth or file a petition for adoption under Section 115(c) of the Domestic Relations Law no later than 30 days after the child's birth.

Considered late if previously eligible

If you change to Family coverage in order to include your spouse/domestic partner or dependents who were previously eligible but unenrolled, their coverage will begin on the first day of the fifth payroll period after you apply.

Exception for new dependent

However, an exception is made if you acquire a new dependent during the late enrollment waiting period after you apply for a change to Family coverage. (For example, if your child is born during the waiting period, the child will be eligible for benefits under your Family coverage beginning with the date of the child's birth.) This exception is not automatic. You must contact your agency Health Benefits Administrator for this benefit.

Exception for court order

If you are subject to a court order mandating that dependents be enrolled immediately in employer health insurance, the late enrollment waiting period will be waived for your eligible dependents covered by the court order. You must provide a copy of the court order and any supporting documents needed to show that the dependents are covered by the order and eligible for coverage under NYSHIP eligibility rules. You must contact your agency Health Benefits Administrator for this benefit.

Add newborn to existing Family coverage

If you have Family coverage, remember to add your newborn child within 30 days, or you may encounter difficulties receiving services. Your child is not automatically covered. You must contact your agency Health Benefits Administrator within 30 days to complete the appropriate forms and to provide a copy of the birth certificate. If you have not yet received a Social Security number for the child, remember to provide a copy of the child's Social Security card as soon as you receive it.

Changing to Family Coverage

If you want to change to Family coverage because (for example):

- You marry or your domestic partner becomes eligible
- You have or adopt a child
- You acquire other dependent children
- You return from military leave
- Your spouse's or partner's other insurance ends

If you apply within 7 days of the event, coverage begins on the day dependent(s) was first eligible.

If you apply within 30 days after the birth or adoption of a newborn, coverage begins on the date of birth.

If you apply more than 7 days but within 28 days of the event, coverage begins on the first day of next payroll period.

If you apply more than 28 days after the event, coverage begins on the first day of fifth payroll period.

If you apply more than 30 days after the birth or adoption of a newborn, coverage begins on the first day of fifth payroll period.

Canceling coverage for your enrolled dependent(s)

You **must** cancel coverage for your dependent when he or she is no longer eligible. See your agency Health Benefits Administrator and read the COBRA chapter in this book.

Changing from Family to Individual coverage

You **must** change to Individual coverage when you no longer have **any** eligible dependents.

You may choose to change from Family to Individual coverage at any time if you no longer wish to cover your dependents, even though they are still eligible. **However, if you are enrolled in the Pre-Tax Contribution Program, you may change the amount of your health insurance deduction during the tax year only in certain situations.** (See page 13, *"Changes permitted only after certain events."*)

Contact your agency Health Benefits Administrator for information about when your dependents' coverage ends if you change from Family to Individual coverage.

Identification Cards

Your HMO card

When you enroll in an HMO, your HMO will provide you with an identification card after your enrollment in the HMO is processed.

Card for dependent(s)

If you have Family coverage, you will also receive a separate card for each covered dependent or a card that lists the names of your covered dependents.

Prescription drug card

Some HMOs issue a separate card for filling prescriptions. Ask your HMO about cards and requirements for filling prescriptions.

Replacing your card

Ask your HMO for a replacement card if your card (or a dependent's) is lost or damaged.

Remember, your HMO identification card does not guarantee NYSHIP enrollment. You are responsible for notifying your agency Health Benefits Administrator promptly when you or your dependents are no longer eligible for NYSHIP coverage. COBRA enrollees are responsible for notifying the Employee Benefits Division.

Costs, Pre-Tax Program and What Your Paycheck Stub Shows

Your share of the premium

New York State helps employees pay for health insurance coverage. After the State's contribution, you pay the balance of your premium through biweekly deductions from your paycheck.

If you enroll in the Empire Plan, the State pays 90 percent of the hospital, medical and mental health/substance abuse components of the premium for Individual coverage. For Family coverage, the State pays 90 percent of those components of your premium as the enrollee, plus 75 percent of the cost of dependent coverage regardless of the number of dependents.

If you enroll in an HMO, the State pays 90 percent of the hospital, medical and mental health/substance abuse components of the premium for Individual coverage. For Family coverage, the State pays 90 percent of those components of your premium as the enrollee, plus 75 percent of those components of the premium for dependent coverage regardless of the number of dependents. However, the State's dollar contribution for those components of your HMO premium will not exceed its dollar contribution for those components of the Empire Plan premium.

For the prescription drug component of your Empire Plan or HMO premium, the State pays 90 percent of your premium as the enrollee plus 75 percent of the cost of dependent coverage regardless of the number of dependents.

Ask your agency Health Benefits Administrator for the premium rates for the Empire Plan and HMOs. Rates effective at the beginning of the program year are announced during the annual Option Transfer Period, usually in November. Rates are also available on the Internet at www.cs.state.ny.us.

COBRA enrollees: New York State does not contribute toward your premium. Please read *"Costs under COBRA"* on page 29.

Note: Payment of premium does not establish eligibility for benefits. You must satisfy NYSHIP eligibility requirements. (See *"Who is Eligible?"* on page 4.)

Pre-Tax Contribution Program (PTCP)

Under the Pre-Tax Contribution Program (PTCP), you may have your share of the health insurance premium deducted from your wages **before** taxes are withheld. Participation in this program may lower your taxes.

Who is eligible for PTCP

If you are an active State employee who receives regular payroll checks and who has premiums deducted from your paychecks, you are eligible to participate in the PTCP. You will not be eligible to participate if you pay for your health insurance directly instead of by payroll deduction (for example, if you are on leave without pay). COBRA enrollees are not eligible for PTCP.

Automatic deductions and opt-out period

If you are eligible for PTCP, you will be enrolled automatically at the time you become eligible for health insurance, unless you file Form PS-404 with your agency Health Benefits Administrator indicating that you decline to participate. New employees who want to opt out must do so at the time they enroll for health insurance coverage. Each year, you will continue with the same pre-tax selection unless you change your selection by filing Form PS-404 with your agency Health Benefits Administrator by the designated fall deadline.

Tax savings

Making your contributions to your health insurance premium on a pre-tax basis (contributions are made before taxes are withheld) reduces your salary by the amount of your contribution. Therefore, you pay taxes based on a lower salary. These salary-based taxes include federal income taxes, Social Security taxes, and most State and local income taxes. (If you live in New Jersey or in Erie, Philadelphia or Pittsburgh, Pennsylvania, you are not allowed to reduce your State or local taxable income by the amount of your health plan contribution. If you live in these areas, only your federal

income taxes and Social Security taxes will be affected. Contact your tax advisor for advice on how participation in the PTCP will affect you.)

The amount you save in taxes will depend on the amount of your income, your premium and the number of withholding allowances that you claim on your taxes.

Consider these hypothetical examples. The figures are estimates. Premium rates and tax rates are subject to change.

Example 1.

Married employee earning $48,000 annually, two withholding allowances, enrolled in the Empire Plan with Family coverage. Biweekly contribution is $52.00 (estimate).

	Approximate Savings	
	Biweekly	**Annual**
FICA (SS Tax)	$ 3.98	$103.43
Federal	8.09	210.40
NYS	3.16	82.20
Total	$15.23	$396.03

Example 2.

Married employee earning $26,254 annually, one withholding allowance, enrolled in an HMO with Family coverage. Biweekly contribution is $56.00 (estimate).

	Approximate Savings	
	Biweekly	**Annual**
FICA (SS Tax)	$ 4.28	$111.38
Federal	8.34	216.84
NYS	3.40	88.52
Total	$16.02	$416.74

Example 3.

Single employee earning $26,254 annually, one withholding allowance, enrolled in the Empire Plan with Individual coverage. Biweekly contribution is $13.00 (estimate).

	Approximate Savings	
	Biweekly	**Annual**
FICA (SS Tax)	$ .99	$25.86
Federal	1.99	51.78
NYS	.78	20.26
Total	$3.76	$97.90

Changes permitted only after certain events

Under the Internal Revenue Service (IRS) rules, you may change your health insurance deduction during the tax year only after one of the following PTCP-qualifying events:

- You have a change in family status (e.g. marriage, birth, death, legal separation, divorce, only dependent child's attaining the maximum age for coverage).
- You are enrolled in an HMO and no longer live or work in that HMO's service area, and you must choose another HMO or the Empire Plan.
- Your spouse loses coverage due to termination of employment and you apply for coverage for your spouse under NYSHIP.
- You first become eligible for health insurance coverage after the beginning of the tax year.
- Your employment with the State terminates or you retire.
- Your spouse has a change in employment status which results in either acquiring or losing eligibility for health insurance coverage.
- You receive a divorce/legal separation and are required under a court order to provide health insurance coverage for your eligible dependent children and/or legally separated spouse.
- There is a significant change in your or your spouse's health coverage which is attributable to your or your spouse's employment.

Changes in pre-tax health insurance deductions that stem from any of these qualifying events must be made within 28 days of the event (30 days for a change of coverage because of the birth of a child). Delays may be expensive. For example, if in June you qualify to change from Family coverage to Individual coverage but you miss the 28-day deadline to make the change, you must keep Family coverage through December. For most options, the extra six months of Family coverage will cost you several hundred dollars.

IRS regulations: Arbitrary changes not permitted during the year

Changes that do not stem from a qualifying event are defined by the IRS as arbitrary health insurance coverage changes. These arbitrary changes in health insurance coverage cannot change the amount of your pre-tax health insurance deduction.

Since there can be no change in your deduction as a result of arbitrary coverage changes once the amount is set for the tax year, NYSHIP enrollees who are enrolled in the PTCP are not permitted to make the following two changes during the tax year:

- **You may not change from Family to Individual coverage while your dependents are still eligible for coverage unless the change stems from a qualifying event.**
- **You may not voluntarily cancel your coverage while you are still eligible for coverage unless the change stems from a qualifying event.**

These limitations apply only to changes made during the tax year when there is no PTCP-qualifying event.

Another money-saving program

Ask your agency Health Benefits Administrator for information on the **Health Care Spending Account**, a flex spending benefit that allows you to set aside up to $3,000 in pre-tax salary to pay for health related expenses that are not reimbursed by your health insurance or any other benefit plan. This program has a restricted enrollment period with a deadline in the fall of each year.

What your paycheck shows

Your paycheck stub identifies your negotiating unit, department and the amount of your biweekly deductions for health insurance. Negotiating Unit 63 is PIA-State Police BCI.

How are you enrolled?

If you are enrolled in the Pre-Tax Contribution Program, your health insurance deduction will be under the heading “Before Tax Deductions” on your pay stub. If you have declined coverage under the PTCP, your health insurance deduction will be under the heading “After Tax Deductions.” If you have elected pre-tax and have a non-federally qualified domestic partner, your health insurance deduction will be split between the two headings. Check this information from time to time. Contact your agency Health Benefits Administrator if you have any questions about what your paycheck shows.

Waiver of premium

In certain situations, you may be entitled to have your health insurance contribution waived for up to one year. The Empire Plan provides a waiver of premium when authorized. However, most HMOs do not provide a waiver of premium. If you enroll in an HMO, check with your agency Health Benefits Administrator before you file for a waiver.

To qualify for a waiver if your HMO does provide one, you must meet **all** three of the following requirements:

1. You must have been totally disabled as a result of sickness or injury, on a continuous basis, for a minimum of six biweekly payroll periods;

   and

2. You must be on authorized leave without pay, unpaid Family and Medical Leave or covered under Preferred List provisions. You are not eligible for the waiver if you are still receiving income through salary, sick leave accruals or retirement allowance;

   and

3. You kept your coverage in effect while you were off the payroll by paying the required full cost of your health insurance premium (your contribution and the State's contribution) if you are on leave without pay, or by paying the employee share if you are covered under Family and Medical Leave or Preferred List provisions.

Waiver is not automatic

A waiver of premium is **not** automatic. You must apply for it, and you must continue to pay your health insurance premiums until you are notified that the waiver has been granted. You will receive a refund for any overpayments.

Waiver ends if...

The waiver may continue for up to one year during your period of total disability **unless:**

- You return to the payroll
- You are no longer covered under leave without pay, Family and Medical Leave or Preferred List provisions
- You are no longer disabled
- You are no longer a State employee (and are not covered under Preferred List provisions)
- You vest your health insurance coverage rights
- You retire
- You die

How to apply for a waiver of premium

To apply for a waiver of premium, obtain Form PS-452 from your agency Health Benefits Administrator. After you, your agency and your physician have filled in the required information, return the completed form to:

Employee Benefits Division
State of New York Department of Civil Service
The State Campus
Albany, New York 12239

You must apply during the period in which you meet the eligibility requirements for a waiver; you may not apply after you return to the payroll or vest or retire.

The Employee Benefits Division will notify you if your waiver has been granted.

Additional waiver of premium

If you received a waiver of premium for up to one year, you must return to work before being eligible for an additional waiver of premium. If you have not returned to work, you may not use accruals to return to the payroll for a brief period in order to qualify for an additional waiver.

If you receive a waiver of premium, return to work and continue health insurance coverage, but must stop working due to a disability, the following rules apply:

- If you must stop working after less than six consecutive biweekly payroll periods, you may resume coverage under the previous waiver for the remainder of the original one-year period which includes the time back to work.
- If you stop working after six or more consecutive biweekly payroll periods, you may apply for a new waiver of premium for an additional one-year period.

There is no lifetime limit to the number of waivers you may receive. The Employee Benefits Division will notify you if an additional waiver has been granted.

How Changes in Your Status Affect Coverage

Special circumstances, such as changes in your payroll status, may affect your enrollment. Make sure that your health insurance coverage is correct. Consult your agency Health Benefits Administrator when your work or payroll status changes.

Leave without pay

If you are on authorized leave without pay, or otherwise leave the State payroll temporarily, you may be eligible to continue your health insurance coverage while you are off the payroll.

Continuing coverage when on leave is not automatic

Coverage while you are on leave for more than 28 days is not automatic. Before going on leave without pay, you must choose to continue coverage or cancel coverage during the period of leave without pay. You must also choose whether you want to resume coverage after you return to the payroll.

If you are going on leave because of military duty or under the Family and Medical Leave Act, special provisions may apply.

Family and Medical Leave Act

Under the Family and Medical Leave Act (FMLA) of 1993, a federal law, eligible workers are entitled to up to 12 weeks of unpaid leave in a 12-month period for certain family and medical reasons. During the Family and Medical Leave, you may continue health insurance and other benefits at the employee share of the premium. But, you will be required to repay the employer share of the premium if you terminate employment following the FMLA leave period. If you go on authorized leave beyond the FMLA leave period, you must pay both the employer and employee share of the health insurance premium. See your agency Health Benefits Administrator for details.

You have the right to apply for a health insurance waiver of premium during the FMLA period. If such a waiver is approved and you go on authorized leave beyond the FMLA period, the waiver would continue. If you remain on authorized leave beyond the period for which the waiver was approved, you must pay both the employer and employee share of the premium. (See *"Waiver of Premium"* on page 14.)

Military leave

If you are on voluntary military leave of 31 days or less, you pay only the employee share of the premium to continue Family coverage. If you are on voluntary military leave that is longer than 31 days, you pay both the employer and employee shares to continue Family coverage. If you are a member of an Armed Forces Reserve or a National Guard Unit called to active duty by a declaration of the President of the United States or an Act of Congress, your covered dependents will be eligible for up to 12 months of Family coverage at no cost to you. You must have had Family coverage for at least 30 days before your activation. If the active duty continues beyond 12 months, you must pay both the employer and employee shares of the premium to continue Family coverage. Before going on military leave (or any leave without pay), you must arrange for coverage through your agency Health Benefits Administrator.

If you do not continue your coverage during military leave, you may reinstate coverage without any waiting period when you return to work. However, exclusions may apply if you have service-related medical problems or conditions.

Cost

To continue your health insurance coverage while on leave, in most cases, you must pay both the employee and employer shares of the premium. If you become disabled while you are on leave, you may be eligible for a Waiver of Premium (See *"Waiver of Premium"* on page 14).

The Employee Benefits Division will notify you each month of the biweekly payment cost and the due date for your next payment. You must send payments to the Employee Benefits Division as explained in the notice. If you do not make your payments on time, your coverage will be canceled and you will not be offered conversion privileges. If you wish to have coverage reinstated while you are on leave, you will have a break in coverage and you will be subject to the late enrollment provisions. (See *"Late enrollment: You wait longer"* on page 8.)

Suspending or canceling coverage while off the payroll

You may suspend or cancel your health insurance coverage for the time you are on leave without pay, Family and Medical Leave or interim suspension. Make arrangements with your agency Health Benefits Administrator before your last day of work. You will not be required to submit any premium payments. Your coverage will end effective the first day of the second payroll period following the payroll period in which you went on leave.

Cancellation for nonpayment of premium

If you do not voluntarily suspend or cancel your health insurance coverage, and you do not make premium payments, your health insurance coverage will be canceled effective 29 days after the last day of the last payroll period for which you were paid.

Consider the consequences

Suspending or canceling your coverage or letting it lapse because you don't pay the premium is a serious step. If you resign, vest or retire while your coverage is suspended or canceled, you and your dependents have no rights to coverage under NYSHIP. If you die and you had suspended or canceled your coverage or let it lapse, your dependents have no rights to coverage as dependent survivors or under COBRA provisions.

You may re-enroll *before* you return to work

If your coverage was suspended or canceled while you were on leave and you want to reinstate your coverage **before** you return to work, you may ask to be reinstated, subject to the late enrollment provision. Write to the Operations Unit, Employee Benefits Division, State of New York Department of Civil Service, The State Campus, Albany, New York 12239.

You may re-enroll *when* you return to work

If your coverage was suspended or canceled while you were on leave, you may re-enroll in NYSHIP when you return to work, provided you still meet the eligibility requirements (see *"Who is Eligible?"* on page 4). Contact your agency Health Benefits Administrator to reactivate your coverage. If you re-enroll, coverage begins on the first day of the second payroll period after the payroll period in which you return to work.

You may re-enroll if you become eligible for FMLA

If your coverage was canceled while you were on leave and then you have a qualifying event for health insurance under the Family and Medical Leave Act (See *"Family and Medical Leave Act"* on page 16.), you may reactivate your coverage at the employee share for the FMLA period. You must have had coverage in effect while in active status immediately prior to the leave. Coverage will begin at the start of the FMLA period, and you must pay for coverage based upon that starting date. When you reactivate coverage, whether during the FMLA leave or upon return to work, there is no late enrollment waiting period.

Leaves of 28 days or less

If you are off the payroll for 28 days or less and have not requested that your coverage be suspended or canceled, the employee and employer shares of the premium (full share) will automatically be deducted from your paycheck when you return to work. **If you do not want coverage while you are off the payroll, you must suspend or cancel your coverage before your last day on the payroll.** Then, you will not have retroactive payments when you return to the payroll.

Health insurance coverage while you're on Workers' Compensation

If you are enrolled in NYSHIP and receive Workers' Compensation because of a work-related injury or occupational condition, be sure you understand that payment for medical care for your work-related injury or condition is the responsibility of the State Insurance Fund. Other medical services for you and your family continue to be the responsibility of your HMO.

However, if you are enrolled in the Empire Plan or in an HMO that participates in **ONECARD Rx,** you should continue to use your health insurance identification card with no out-of-pocket expense to obtain prescription drugs related to your Workers' Compensation injury or illness.

Layoff and Preferred List

Coverage continues for a year

If you are laid off because a job is abolished and your name has been placed on a Preferred List, you may continue your health insurance coverage for up to one year or until you are re-employed in a benefits-eligible position by a public or private employer, whichever occurs first. While covered under Preferred List provisions, you are required to pay only the employee's share of the premium. Check with your agency Health Benefits Administrator for information about other changes in your health insurance benefits.

Other rules for continuing coverage

If you are laid off and are not on a Preferred List, you will also be eligible to continue your coverage for up to one year or until you are re-employed, whichever occurs first, by paying only the employee's share of the premium if:

- You were employed on a permanent, full-time basis and eligible for NYSHIP coverage and you are laid off because a position was abolished. You are not eligible to continue health insurance under Preferred List provisions if your appointment was a provisional or temporary appointment.

or

- You are in a benefits-eligible position in the non-competitive class with tenure under Section 75 of the Civil Service Law.

COBRA extends coverage

After a year, or when your coverage ends, if you are not eligible for health insurance in vestee or retiree status, you may be eligible to continue coverage under COBRA for up to 18 months. (See *"COBRA: Continuation of Coverage"* on page 27.)

Contact your agency Health Benefits Administrator if you have any questions about how a change in your status may affect your health insurance coverage.

Continuing Coverage When You Retire

Eligibility for retiree coverage

When you retire, you may continue coverage for yourself and your eligible dependents if you meet certain requirements. The benefits may differ somewhat from those you receive as an active employee. Your agency Health Benefits Administrator can provide information about health insurance benefits for retirees.

Note: Read this information carefully. Retirement System requirements for pension benefits are different from NYSHIP requirements for continuing health insurance as a retiree or vestee. For example, part-time service is not counted the same way for health insurance as it is counted for State-administered retirement benefits. **Do not assume that your health insurance benefits will continue automatically when you retire.** Also, if you are eligible but do not want your coverage to continue when you retire, you must contact your agency Health Benefits Administrator.

You must meet all three eligibility requirements in order to continue your health insurance coverage:

1. Complete the minimum service period

First, you must have completed a minimum service period which is determined by the date on which you last entered State service.

- If you were last hired **before April 1, 1975,** you must have had at least five years of benefits-eligible State service or at least five years of combined benefits-eligible service with the State and one or more Participating Employers or Participating Agencies*.
- If you were last hired on or **after April 1, 1975,** you must have had at least 10 years of benefits-eligible State service or at least 10 years of combined benefits-eligible service with the State and one or more Participating Employers or Participating Agencies*.

Less than full-time employment: Periods of less-than-full-time employment will be considered as full-time if you were eligible for health insurance. Periods of employment in which you did not meet the eligibility requirements will not be counted. Periods when you were paying both the employer share and employee share of the NYSHIP premium as an active employee or while on leave without pay do not count toward the minimum service requirement.

Participating Employer/Participating Agency* employment: If you were employed by an employer or agency that participates in NYSHIP on the date you retire, all of your service there in a benefits-eligible position will count toward the minimum service requirement for continuing NYSHIP coverage in retirement. If you were employed by an employer or agency that no longer participates in NYSHIP when you retire, only your service there in a benefits-eligible position before the employer/agency withdrew from NYSHIP will count. If you were

employed by an employer or agency that is eligible for Participating Employer or Participating Agency status in NYSHIP but has never joined, your service there will not count.

**A Participating Employer is a government agency in New York State such as the Thruway Authority or Metropolitan Transit Authority that is maintained and financed from special administrative funds and participates in NYSHIP. A Participating Agency is a city, town, municipality, or school district in New York State that participates in NYSHIP. (Note: By law, New York City does not participate in NYSHIP, so service with New York City does not count toward the minimum service requirement for continuing NYSHIP coverage in retirement.)*

2. Satisfy requirements for retiring as a member of a retirement system

Second, you must be qualified for retirement as a member of a retirement system administered by New York State (such as the New York State and Local Employees' Retirement System, the New York State Teachers' Retirement System, or the New York State and Local Police and Fire System) or any of New York State's political subdivisions. Be sure to check with your retirement system as part of your retirement planning.

If you are not a member of a retirement system administered by the State, you must satisfy one of the following conditions:

- You must meet the age requirement of the Employees' Retirement System retirement tier in effect at the time you last entered service, or
- You must be qualified to receive Social Security disability payments.

3. Be enrolled in NYSHIP

Third, you must be enrolled in NYSHIP as an enrollee or a dependent at the time of your retirement. For example, if you were on leave and canceled your coverage, and then retire, you may not be eligible for health insurance as a retiree.

Remember to contact your agency Health Benefits Administrator to discuss your coverage in retirement and to have your status changed from "active" to "retired."

Note: If you retire but delay collecting your State pension, you may continue your NYSHIP coverage under retiree provisions, provided you meet the eligibility requirements listed above. You will make monthly premium payments directly to the Employee Benefits Division. Ask your agency Health Benefits Administrator about "Constructive retirement."

Re-enrolling as a retiree

After you retire, you may cancel coverage, then re-enroll. Under most circumstances you will be subject to a waiting period before your coverage again becomes effective. Any sick leave credits will be maintained on your record until you reactivate your enrollment.

Disability retirement

Ordinary disability retirement: For an ordinary (not work-related) disability retirement, the age requirement is waived, but you must meet the minimum service requirement.

Work-related disability retirement: For a disability retirement resulting from a work-related illness or injury, the age requirement and the minimum service requirement are waived.

To maintain NYSHIP eligibility, you must continue your health insurance coverage while you wait for the decision on your disability retirement. If you do not continue coverage or if you fail to make the required payments while on leave or in vestee status, coverage for you and your dependents will end. Coverage may end permanently. If your disability retirement is not approved, you will not be eligible to re-enroll in NYSHIP as, for example, a vestee or COBRA enrollee.

Deadline: If you have not continued your coverage while on leave or in vestee or COBRA status and a retroactive retirement is granted, call the Employee Benefits Division right away at 518-457-5754 (Albany area) or 1-800-833-4344 to ask about reinstating coverage. Call as soon as you have the decision on your disability retirement. You must apply in writing for reinstatement of your NYSHIP coverage **within 60 days** of the date on the letter from your retirement system announcing the decision to grant your disability retirement. If coverage is reinstated for an ordinary disability retirement, you will be required to pay premiums retroactively.

How you pay

When you retire, you will pay your share of the health insurance premium through deductions from your monthly State pension check or by making monthly payments directly to the Employee Benefits Division. It may take several months for the Employee Benefits Division to receive the Retirement Number assigned to you by the Retirement System, and begin taking monthly health insurance deductions from your pension. Meanwhile, you will be billed directly each month for your share of the premium. Be prepared to make these payments each month until pension deductions begin.

Sick leave credits

You may be entitled to use the value of your accumulated unused sick leave to offset all or part of the cost of your health insurance during retirement whether you are in the Empire Plan or an HMO. This will not affect the value of your sick leave for pension purposes.

Lifetime monthly credit

When you retire, your unused sick leave is converted into a dollar amount by dividing the total dollar value of your sick leave by your actuarial life expectancy in months. The result is a lifetime monthly credit which reduces your cost for health insurance for as long as you remain enrolled in any NYSHIP option. The amount of your monthly credit will remain the same throughout your lifetime. However, the balance you pay may change each year. (See *"Estimate the value of your sick leave credit"*, on page 22.)

At the time you retire, if you are eligible to use sick leave credits, your agency will report your hourly rate of pay and accumulated sick leave hours to the Employee Benefits Division. Six to eight weeks after you receive your last payroll check, you will receive a letter verifying your monthly sick leave credit and the current cost of your retiree health insurance coverage. **Keep this letter for future reference.** If you do not receive this information within eight weeks after your last payroll check, write to the Employee Benefits Division or call 518-457-5754 (Albany area) or 1-800-833-4344.

You can use a maximum of 165 working days of earned sick leave to calculate your sick leave credit.

If the credit from your unused sick leave does not fully cover your share of the monthly premiums, you must pay the balance. If the credit exceeds your share of the monthly premiums, you will not receive the difference.

Premium rates are recalculated each year. If the retiree premium rises, the balance you must pay will also rise. New rates are announced by mail and posted on our Web site during Option Transfer Period each year. Each year, to calculate the balance you will pay in the new calendar year, subtract your monthly sick leave credit from the new monthly premium.

When you retire, if the total dollar value of your sick leave amounts to $100 or less, it will be calculated in the same manner as dollar values of $100 or more to provide a lifetime monthly amount of no less than $.01 per month. Or, you may choose to have a credit of less than $100 applied to monthly premiums until the amount runs out. Then, you will contribute the usual enrollee share. Before you retire, you must notify the Employee Benefits Division if you want to use this runout sick leave method.

If you retire while covered under Preferred List provisions, and you retire within one year of your termination, you will be eligible to have sick leave credits applied to your premium in retirement.

Dual Annuitant Sick Leave Credit

At the time of your retirement, you may specify that you want your dependent survivors (see *"Coverage for Your Dependent Survivors"* on page 25) to be able to use your monthly sick leave credit toward their NYSHIP premium if you die. This is called the Dual Annuitant Sick Leave Credit. **If you want this option, you must choose it before your last day on the payroll.**

If you choose the Dual Annuitant Sick Leave Credit, you will use 70 percent of your sick leave credit for your premium for as long as you live. Your eligible dependents who outlive you may continue to use 70 percent of the monthly credit for their NYSHIP premium.

In the example in *"Estimate the value of your sick leave credit"* on page 22, your monthly sick leave credit is $30.25. If you choose the Dual Annuitant option, your monthly sick leave credit will be 70 percent of $30.25, which is $21.18 in this example.

The monthly sick leave credit (of $21.18 in this example) is available to your dependents as long as they remain eligible for NYSHIP and are enrolled as dependent survivors. The monthly premium for your dependents' continuation in NYSHIP will be reduced by your monthly sick leave credit ($21.18 in this example). This credit cannot be applied to a COBRA premium and cannot be combined with your spouse's (or domestic partner's) sick leave credit, if any.

To elect Dual Annuitant Sick Leave, contact your agency Health Benefits Administrator before you retire. You may choose the Dual Annuitant option whether you have Individual or Family coverage at the time you retire. **If you do not indicate a choice before your retirement becomes effective, all of your leave credit (up to a maximum of 165 days) will be applied to your premium automatically and your dependent survivors will not have any sick leave credit to offset the cost of the NYSHIP premium.**

This opportunity to elect Dual Annuitant Sick Leave is available only once, at the time you retire. Once you elect Dual Annuitant Sick Leave, you may not discontinue it. If your dependents die before you, you will retain the 70 percent sick leave credit. If you remarry, your 70 percent sick leave credit will be available to your covered dependent survivors.

Married couples who are both eligible for NYSHIP

If you and your spouse (or domestic partner) have chosen a single Family coverage, each of you keeps the right to apply sick leave credits toward your health insurance premium in retirement. Your dependent spouse may choose to re-enroll independently in NYSHIP at any time. Upon re-enrolling, a monthly sick leave credit will be established for your retired spouse, provided the value of his or her unused sick leave can be documented.

Therefore, at retirement, your spouse must ask his or her agency to complete PS-410 "State Service Sick Leave Credit Preservation" form. This form provides evidence of your spouse's State service and sick leave credit if he or she wants to obtain New York State Health Insurance Program coverage in the future. Or, at retirement, your spouse may request a letter from his or her agency which verifies total sick leave accruals and indicates salary and negotiating unit. Your spouse must request this form or letter. It is provided only on request when the employee is covered as a dependent.

When your spouse applies for coverage in his or her own name, your spouse should send this completed form PS-410 or agency verification with a letter requesting coverage to the Employee Benefits Division. A spouse who is entitled to the Dual Annuitant Sick Leave Credit may elect it at the time enrollment is reactivated. For information on reactivating enrollment in NYSHIP, your spouse should contact the Employee Benefits Division.

When credit ends

Your monthly sick leave credit ends when you die and may not be used by your surviving dependents, unless you chose the Dual Annuitant Sick Leave Credit. See *"Coverage for your Dependent Survivors"* on page 25.

Eligible spouse may reactivate own NYSHIP enrollment

Whether or not you choose the Dual Annuitant Sick Leave Credit, if your spouse is a former New York State employee and meets the eligibility requirements for continuing health insurance coverage in retirement, your spouse keeps the right to reactivate his or her own NYSHIP enrollment at any time. For example, if you predecease your spouse, your spouse may either continue in NYSHIP as a dependent survivor, or reactivate enrollment in his or her own right.

To establish the sick leave credit, **your spouse must document the value of his or her unused sick leave.** Therefore, at retirement your spouse should request a letter from his or her agency which verifies total accumulated sick leave accruals and indicates negotiating unit and salary. For information on reactivating enrollment in NYSHIP, your spouse should contact the Employee Benefits Division in the Department of Civil Service.

Estimate the value of your sick leave credit

Use this worksheet or the electronic calculator on our Web site, www.cs.state.ny.us. This worksheet is for estimating your sick leave credit only. The worksheet is for full-time and part-time employees. If you are paid on an hourly basis, use your hourly salary as the Hourly Rate of Pay.

Work Sheet

Calculate your Hourly Rate of Pay (HRP)

Step 1. Determine "hours worked in a day": Divide the number of hours in a workweek by 5. For example, a 40-hour week divided by 5 equals an 8-hour day, even if you work 4 days of 10 hours each.

Hours worked in a week ÷ 5 =
Hours worked in a day:_____.

Step 2. Determine HRP: Divide your total annual salary at the time of retirement (basic annual salary plus additional constant salary factors such as location pay, shift or geographic differential, inconvenience pay) by one of the following predetermined numbers: 2088 for jobs that are 8 hours a day, 1957 for jobs that are 7 1/2 hours a day, and 1827 for jobs that are 7 hours a day. (Please contact your agency Health Benefits Administrator for calculations other than the three stated above.)

Annual Salary ÷ Predetermined Number =
Hourly Rate of Pay (HRP):_____.

Calculate your Sick Leave Credit

Step 3. Determine the total dollar value of your sick leave: Multiply your hourly rate of pay by the number of sick leave hours you have accumulated up to a maximum of 165 days.

HRP x Hours Unused Sick Leave =
Total Dollar Value of Sick Leave:_____.

Step 4. Determine your monthly credit: Divide the total dollar value of your sick leave by your life expectancy from the table below:

Total dollar value ÷ Life Expectancy =
Monthly Credit:_____.

Example

You want to retire at age 62 (three months from now). Your gross annual salary is $30,000 and you have 400 hours of unused sick leave.

Step 1. Hours Worked in a day:

8 (hours worked in a day)
5) 40 (hours worked in a week)

Step 2. Hourly Rate of Pay (HRP):

$ 14.37 (HRP)
2088) 30,000 (Annual Salary)

Step 3. Total dollar value of your sick leave:

$ 14.37 (HRP) x (hours unused sick leave) =
$5,748 (Total Dollar Value)

Step 4. Your Monthly Credit:

$ 30.25 (Monthly Credit)
Life expectancy - 190) $5,748 (Total Dollar Value)
(from table below)

(To use the electronic calculator on our Web site, www.cs.state.ny.us, click on "Employee Benefits." Under NYSHIP, select "Employees of: New York State." Choose your group. Choose "Continuing Coverage When You Retire" and click on "Estimate the Value of Your Sick Leave Credit." Click on "Sick Leave Electronic Calculator.")

Actuarial Table*

AGE AT RETIREMENT	LIFE EXPECTANCY	AGE AT RETIREMENT	LIFE EXPECTANCY
50	302 months	59	217 months
51	292 months	60	208 months
52	282 months	61	199 months
53	273 months	62	190 months
54	263 months	63	181 months
55	254 months	64	173 months
56	245 months	65	164 months
57	235 months	66	156 months
58	226 months	67	148 months

Etc.

*This table is for employees in the NYS and Local Police and Fire Retirement System and is for regular retirement only. A different actuarial table applies to disability retirements. If you need actuarial rates for different retirement ages, ask your agency Health Benefits Administrator. For employees in the NYS and Local Employees' Retirement System, different actuarial tables apply for regular and disability retirements.

Using the example above, you would have $30.25 of sick leave credit each month to help pay the cost of your health insurance as long as you live. If, for example, your share of the monthly cost of health insurance is $100, your total monthly cost would be $100 minus your sick leave credit of $30.25, or $69.75. The amount of $69.75 would be deducted from your pension or billed to you directly each month. **Keep in mind, as the premium increases or decreases, the amount you must pay each year will also increase or decrease.** Your monthly credit of $30.25 will not change.

This chart shows the use of single annuitant sick leave credit. If you choose Dual Annuitant Sick Leave Credit at the time of your retirement, 70 percent of the monthly credit ($21.18 in this example) is available to you and your surviving dependent to apply toward the health insurance premium.

Deferred Health Insurance Coverage

When you retire, you may defer (delay the start of) your retiree health insurance coverage and the use of your sick leave credits indefinitely, if you have other health insurance coverage, for example through your spouse's employer or through post-retirement employment.

There may be advantages to deferring coverage. During the period of deferment, you do not have to pay the NYSHIP premium. Also, when you start your retiree coverage, the monthly credit for your sick leave will be higher than it would have been at the time you retired because it will be calculated when you are older. This will reduce the amount of the health insurance premium you will pay. You may start your retiree health insurance coverage at any time without a waiting period.

If you die while you are in deferred coverage status and had Family coverage at the time you retired and deferred your coverage, your eligible dependents may re-enroll in NYSHIP. They must write to the Employee Benefits Division requesting re-enrollment in NYSHIP **within 90 days** of the date of your death. Eligibility requirements for your dependents to re-enroll in NYSHIP are the same as if you had continued your coverage into retirement.

If you choose Dual Annuitant Sick Leave Credit at the time of retirement and die while in deferred status, your eligible survivors will retain the 70 percent sick leave credit. The amount will be calculated based on your age at the time of death.

If you want this option, you must choose it before your last day on the payroll.

Contact your agency Health Benefits Administrator if you have questions about deferring your coverage.

If you return to work

If you return to State service in a benefits-eligible position, ask your agency Health Benefits Administrator about how your return to work affects your sick leave credit and your status as a retired enrollee in NYSHIP. If you or a dependent is eligible for Medicare, it is important for you to understand how your re-employment will affect NYSHIP coordination with Medicare. Talk to your agency Health Benefits Administrator and be sure your record is updated to show your new status so that your benefits will be correct.

SUMMARY

BEFORE YOU RETIRE:

- **Check the requirements for continuing your health insurance in retirement:**
  - Talk with your agency Health Benefits Administrator (HBA). Be especially sure to discuss the minimum service requirements.
  - Carefully read the retirement information in this book.
- **If you are eligible to continue your health insurance benefits, ask your agency Health Benefits Administrator to:**
  - Make sure the information on your enrollment record is up to date for you and your dependents: dates of birth, correct spelling of names, effective dates, address, etc.
  - Provide information about Dual Annuitant Sick Leave Credit (through which your sick leave credit can be applied toward your surviving dependent's premium) if you accrue sick leave.
  - Provide information about Deferred Health Insurance Coverage if you are eligible for this benefit.
- **Ask your HMO about retiree benefits.**
- **Contact your Social Security Administration office three months before you or a dependent turns 65 to enroll in Medicare Parts A and B. As a retiree, you must have Medicare Parts A and B *in effect* on the first day of the month in which you reach 65.**

Although Medicare allows you to enroll up to three months after your 65th birthday, NYSHIP requires you to have Medicare Parts A and B in effect on the first day of the month in which you reach 65. **If you do not apply three months before your birthday, you will have a waiting period before Medicare becomes effective. During that waiting period, you will have a gap in your coverage that could be very costly for you.**

If you or a dependent is already 65 or over, you must have Medicare Parts A and B *in effect* as your primary coverage the first day of the month following a "runout" of 28 days after you retire. Note: Medicare becomes primary for your domestic partner the first of the month in which the domestic partner reaches age 65, regardless of your employment status. Also, regardless of age, Medicare provides primary coverage when you retire if you or your dependent is disabled or develops end stage renal disease.

Also see *"Medicare: A federal program"* on page 30.

- **Moving when you retire?**

Before you retire:

- Notify your agency Health Benefits Administrator of any address change.
- Check with your agency to see if you need to change your health insurance option.

After you retire:

- Write to the Department of Civil Service Employee Benefits Division to report any address change.

- **If you do not meet the requirements to continue coverage as a retiree, COBRA or a direct-pay policy will allow you to continue health insurance benefits. You will receive this information at your home address. Read the chapters on COBRA Continuation of Coverage and Changing from NYSHIP to a Direct-Pay Conversion Contract or ask your agency Health Benefits Administrator for details.**

Continuing Coverage as a Vestee

Health insurance as a vestee

If your employment with the State ends before you reach retirement age and you vest (secure rights to) your retirement allowance, you may continue your health insurance coverage while you are in vested status provided:

- you have vested as a member of a retirement system administered by the State or one of its political subdivisions, such as a municipality;

  and

- you have met the minimum service requirement, but not the age requirement for continuing health insurance in retirement, at the time employment is terminated. (See *"Eligibility for retiree coverage"* on page 18.)

To continue coverage as a vestee, before your last day of work be sure to contact your agency Health Benefits Administrator to arrange for continuation.

What you pay

If you choose to continue your coverage while in vested status, you are responsible for paying both the employer and employee shares of the health insurance premium. You will be billed monthly.

No sick leave credit

In no case may sick leave credits be applied toward health insurance premium costs either while you are in vested status or after retiring from vested status. (Sick leave credits can be applied toward your premium only if you retire directly from active employment or from Preferred List coverage, not if you leave employment in vested status and retire later.)

Coverage ends permanently if you do not continue as a vestee

If you are eligible to continue coverage during vested status, but you do not do so, or if you fail to make the required premium payments as a vestee, coverage for you and your dependents will be terminated permanently. You may not re-enroll as a vestee at a later date and you lose eligibility for coverage as a retiree.

Note: If your spouse is eligible for NYSHIP coverage in his or her own right, you may be able to continue coverage as your spouse's dependent. This is a less-expensive alternative to full-share vested coverage.

If you are a vestee and you have NYSHIP coverage as a dependent through your spouse, you may re-establish coverage as an enrollee in your own name at any time as long as you have not allowed your coverage to lapse. Ask your spouse's agency Health Benefits Administrator for information. Also contact the Employee Benefits Division to begin coverage in your own name. Act promptly if a pending divorce or other change means you will be losing coverage through your spouse.

Coverage for Your Dependent Survivors

The New York State Health Insurance Program provides an extended benefits period for your survivors if you die.

Extended benefits period at no cost

If you die while you are on the State payroll, your enrolled dependents will continue to receive coverage without charge for five biweekly payroll periods beyond the payroll period for which your last health insurance deduction was taken.

If you die while you are retired, your enrolled dependents will have health insurance coverage for three months beyond the month in which you die. The last two months of coverage will be provided at no cost to your dependent survivors.

If you die while you are in vested status, your enrolled dependents will have health insurance coverage for three months beyond the month in which you die. The last two months of coverage will be provided at no cost to your dependent survivors.

If you die while you are enrolled in NYSHIP through COBRA, your enrolled dependents will be eligible for COBRA continuation coverage or conversion to a direct-pay contract. (See *"Changing From NYSHIP to a Direct-Pay Conversion Contract"* on page 30.)

Who to call

Survivors should contact the employee's agency Health Benefits Administrator. (See *"Important Telephone Numbers"* on the inside back cover.) The Employee Benefits Division sends information about eligibility, enrollment and payment methods to survivors during the extended benefits period.

Coverage after the extended benefits period ends

Your **unremarried spouse,** or domestic partner who has not acquired another domestic partner, and eligible dependent children may be allowed to continue their coverage under NYSHIP after the extended benefits period ends. **If they are eligible for dependent survivor coverage but choose not to participate or fail to make the required payments, coverage will end permanently. They may not re-enroll.**

Whether they are eligible for dependent survivor coverage and what their premium will cost depend on the following circumstances:

If you die in the line of duty or as a result of a work-related illness or injury, regardless of your age at the time of death or your length of service, the State will pay 100 percent of the cost of NYSHIP coverage, up to the cost of the Empire Plan premium, for your dependents as long as they remain eligible.

If your death is not the result of a work-related illness or injury:

If at the time of your death you were an active employee who had 10 years of service with New York State or an agency eligible to participate in NYSHIP and were 10 years or less from retirement in a retirement system administered by New York State or any of its political subdivisions, your dependents will make the same contribution that active employees make toward the cost of the Empire Plan or HMO premium.

If at the time of your death you were an active employee who had 10 years of service but were not within 10 years of retirement, your dependents would be required to pay both the employer's and the employee's share of the premium.

It may also be helpful to know that if at the time of your death, you were a retiree who retired on or after April 1, 1979, with 10 or more years of active service with the State or with a combination of service with the State, or a Participating Employer or Participating Agency or any political subdivision, such as a municipality, which has been eligible to participate in NYSHIP, your dependents will make the same contribution as active employees make toward the cost of the Empire Plan or HMO premium. **Note:** If at the time of your retirement you had chosen the Dual Annuitant Sick Leave Credit, that credit would continue to be used to reduce the enrollee share of the premium for dependent survivors.

If at the time of your death you were a vestee, your dependents may continue coverage by paying the full cost of the Empire Plan or HMO premium.

Cards and benefits

During the extended benefits period, your survivors should continue to use the card(s) they already have under your identification number.

After the extended benefits period ends, if your dependent then enrolls for dependent survivor coverage, the Employee Benefits Division will change the file to the survivor's own name and identification number. Benefits may change to retiree benefits. The dependent survivor should check with the HMO about retiree benefits and new cards.

Coverage for your eligible dependents if your spouse or domestic partner loses eligibility or dies

If your surviving spouse or domestic partner loses eligibility or dies, your eligible dependent children may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. (See *"Your dependents"* on page 4.) If they no longer meet these requirements, they may enroll in COBRA or convert to a direct-pay contract.

Option changes for dependents

Survivors are covered by the same rules as active employees for changing options. (See *"Annual Option Transfer Period"* on page 2.)

If your family is not eligible for dependent survivor coverage

If your spouse or domestic partner and children are not eligible for survivor coverage under the New York State Health Insurance Program, they may be eligible to continue their coverage in NYSHIP under COBRA or convert to a direct-pay conversion contract as described in the two following sections.

COBRA: Continuation of Coverage

Continuation coverage: important benefit

This section explains your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you and your covered dependents. The law requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health care coverage called "continuation coverage" at group rates in certain instances where coverage under the program would otherwise end. The health care benefits you may continue are the same benefits you receive as an active employee enrolled in the New York State Health Insurance Program (NYSHIP). There is also no change in benefits when your dependent enrolls in COBRA.

This section summarizes your rights and obligations under the continuation coverage provisions of the law. If your spouse or domestic partner is also covered under NYSHIP, your spouse or domestic partner should take the time to read this carefully.

Who is eligible?

If you have canceled your NYSHIP enrollment while on leave under the Family and Medical Leave Act, and do not return to work, you may choose COBRA coverage. Enrollees who are entitled to receive Medicare benefits may enroll for COBRA coverage following a COBRA-qualifying event. Note: "Entitled to receive Medicare benefits" means that the person could submit claims to Medicare and receive reimbursement, not just being eligible to enroll by virtue of being over 65, for instance, or being in a Medicare waiting period.

You

If you are an active employee enrolled in NYSHIP, you have a right to choose this continuation coverage if you lose your group health care coverage because of a reduction in your hours of employment or the termination of employment.

Your spouse/domestic partner

The spouse or domestic partner of an active employee covered by NYSHIP has the right to choose continuation coverage if the spouse's or partner's coverage under NYSHIP is lost for any of the following reasons:

1. The death of the employee;
2. Termination of the employee's employment;
3. Reduction in employee's hours of employment;
4. Divorce or legal separation, or termination of domestic partnership (Spouse does not automatically lose coverage in NYSHIP if legally separated from employee. However, if legally separated and the employee chooses to discontinue the spouse's dependent coverage under NYSHIP, the spouse is eligible to continue coverage under COBRA);
5. Employee is a COBRA enrollee and becomes entitled to receive Medicare benefits.

Dependent children

A dependent child of an employee covered by NYSHIP has the right to continuation coverage if coverage under NYSHIP is lost for any of the following reasons:

1. The dependent ceases to be an eligible "dependent child" under NYSHIP;

2. The termination of a parent's employment;
3. A reduction in hours of a parent's employment with New York State;
4. Parents' divorce or legal separation. (Note: Under NYSHIP, a dependent child does **not** automatically lose coverage because of parents' legal separation);
5. A parent who is a COBRA enrollee becomes entitled to receive Medicare benefits; or
6. The death of a parent.

Choice of option and coverage

An employee, spouse/domestic partner or dependent child who continues coverage under COBRA will continue in the same option in which the employee was enrolled. A COBRA enrollee may change to a different option during the annual Option Transfer Period or when moving under the circumstances described in *"Changing options outside the Option Transfer Period"* on page 2. When two or more persons (enrollee, spouse/domestic partner, children) covered under the same Family contract seek COBRA coverage as a result of the same qualifying event, they must continue Family coverage; they may not elect Individual COBRA coverages, unless both spouses/domestic partners are State employees, until the next Option Transfer Period. During the Option Transfer Period, each COBRA beneficiary may elect to change to Individual coverage in a different plan from that of the family unit.

Proof of insurability

You do not have to show that you are insurable to choose continuation coverage.

60-day deadline to apply in writing for COBRA

Under COBRA, *the employee or a family member is responsible for* informing the Employee Benefits Division of the New York State Department of Civil Service of a divorce or termination of a domestic partnership, of the Social Security determination that a qualified beneficiary was disabled at the time of the employee's termination or reduction in hours, or of a child's losing eligible dependent status under NYSHIP, **within 60 days** from the date coverage ends. Other people acting on your behalf may provide written notice to the Employee Benefits Division of a COBRA-qualifying event.

If the Employee Benefits Division does not receive notice in writing within that 60-day period, regardless of the reason, the enrollee or dependent will not be entitled to choose continuation coverage. *Your employing agency is responsible for* notifying the Employee Benefits Division of a reduction in your hours or termination of your employment.

When you or your agency Health Benefits Administrator notifies the Employee Benefits Division of an event that entitles you to COBRA coverage, the Division will, in turn, notify you, the employee, that you have the right to choose continuation coverage. If the Division indicates that you do have the right, you must then inform the Employee Benefits Division that you want continuation coverage within 60 days from the date you would lose coverage because of a qualifying event or 60 days from the date you are notified of your eligibility for continuation of coverage, whichever is later.

A dependent (spouse/domestic partner or child) who loses NYSHIP coverage and wishes to continue coverage as a COBRA enrollee must send a written request to the Employee Benefits Division within 60 days from the date coverage would otherwise end.

If you or your eligible dependent, or someone else acting on your behalf, does not choose continuation coverage, NYSHIP insurance coverage will end.

If you choose continuation coverage, New York State is required to offer you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

How long you may keep COBRA coverage

You, the employee, will have the opportunity to maintain continuation coverage for 18 months. However, the continuation coverage period will be extended to 29 months for you and your enrolled dependents if you or a dependent is disabled (under Social

Security Act provisions defining disabilities) at the time of the initial COBRA qualifying event or during the first 60 days of COBRA coverage. To qualify for this extension, you must notify the Employee Benefits Division within 60 days of the disability award from Social Security and before the end of the 18-month continuation period.

If, during your 18- or 29-month continuation coverage period, another event takes place that would entitle a dependent spouse or child to his or her own continuation coverage, the continuation coverage may be extended for the spouse or child. However, in no case will any period of continuation coverage be more than 36 months from the original COBRA qualifying event.

Dependents who were covered at the time of your initial qualifying event, and newborns or newly adopted children added to your COBRA continuation coverage within 30 days of birth or final adoption during your period of COBRA coverage, are considered qualified beneficiaries with their own rights to continue COBRA coverage for up to 36 months in the event of a second qualifying event. Other dependents added to your COBRA coverage, such as a newly acquired spouse or child who returns to school full-time, do not have continuation rights apart from yours.

An enrolled spouse/domestic partner and dependent children who lose NYSHIP eligibility due to a COBRA qualifying event have the opportunity to maintain COBRA continuation coverage for up to 36 months.

When you no longer qualify for COBRA coverage

Continuation coverage may be cut short for any one of the following reasons:

1. If New York State no longer provides group health care coverage to any of its employees; or
2. If the premium for your continuation coverage is not paid on time; or
3. If you become eligible for Medicare after enrolling in COBRA, your COBRA coverage ends when you become entitled to receive Medicare benefits. (In this case, your covered dependents may continue COBRA coverage for up to 36 months from their original COBRA qualifying event.)

Costs under COBRA

COBRA enrollees pay 100 percent of the premium for continuation coverage plus a two percent administrative fee. (If your coverage continues beyond 18 months due to a determination of disability under the Social Security Act, the administrative fee may increase to 50 percent for the 19th through the 29th month.) The Employee Benefits Division will send the COBRA enrollee monthly bills for the COBRA premium. COBRA enrollees will have an initial grace period of 45 days starting with the date they choose continuation coverage to pay any premium; and after that initial 45-day grace period, they will have a grace period of at least 30 days to pay any subsequent premiums. Payment is considered made on the date of the postmark.

To cancel COBRA

Notify the Employee Benefits Division in writing if you want to cancel your COBRA coverage.

Conversion rights after COBRA coverage ends

At the end of the 18-month, 29-month or three-year continuation coverage period, you will be allowed to convert to direct-pay conversion contracts with the Empire Plan's hospital and/or medical carrier if you are enrolled in the Empire Plan, or with your HMO if you are an HMO enrollee.

If you choose COBRA coverage, you must exhaust those benefits before converting to a direct-pay conversion contract. If you choose COBRA coverage and fail to make the required payments or cancel coverage for any reason, you will not be eligible to convert to an individual policy.

Whom to contact

If you have any questions about COBRA, please contact your agency Health Benefits Administrator.

Changing From NYSHIP to a Direct-Pay Conversion Contract

Under certain conditions, NYSHIP enrollees and their covered dependents are entitled to direct-pay conversion contracts after NYSHIP coverage ends or after continuation coverage in NYSHIP under COBRA is exhausted. Refer to your HMO contract for information about your direct-pay conversion rights. Notification procedures and deadlines for applying for conversion coverage vary among HMOs.

The benefit package and the premium costs for direct-pay conversion contracts differ from what you have had under NYSHIP.

You or your covered dependents do not need to provide evidence of insurability.

Medicare: When You Must Enroll and Coordinating with NYSHIP

This section explains when NYSHIP requires you to enroll in Medicare. NYSHIP requirements are not the same as Social Security or Medicare requirements. Do not depend on Social Security, Medicare, another employer or your HMO for information on NYSHIP requirements. If you have questions about NYSHIP requirements for enrolling in Medicare, contact your agency Health Benefits Administrator.

Medicare: A federal program

Medicare is a federal health insurance program for people who are age 65 or older, or have been entitled to Social Security disability benefits for 24 months, or have end stage renal disease (permanent kidney failure). Medicare is directed by the federal Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration). Local Social Security Administration offices take applications for Medicare and provide information about the program.

"Original" (fee-for-service) Medicare has two parts: **Part A, hospital insurance** which can help pay for inpatient hospital care, care in a skilled nursing facility, home health care and hospice care; and **Part B, medical insurance** which can help 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.

Primary Coverage

A health insurance plan provides "primary coverage" when it is responsible for paying health benefits before any other group health insurance is liable for payment. Be sure you understand which plan provides your primary coverage.

NYSHIP is primary for most active State employees

NYSHIP (Empire Plan or HMO) provides primary coverage for you, your enrolled spouse and other covered dependents while you are an active State employee, regardless of age or disability. There are exceptions: Medicare is primary for your domestic partner at 65, and provides primary coverage for an active employee or the dependent of an active employee when Medicare eligibility is due to end stage renal disease, as explained below. Also see "*When an active employee is enrolled as a retiree's dependent*" on page 32.

If you or your spouse or other dependent turns 65 or becomes disabled while you are an active employee, you may delay enrollment in Medicare Parts A and B until you retire, without penalty. Or, you may enroll as soon as you are eligible and delay activating your benefits until you retire. Or, you may enroll in Part A only, to be eligible for some secondary (supplemental) benefits from Medicare for hospital-related services. There is usually no premium for Medicare Part A.

As an active State employee, eligible for Medicare because of age or disability, you can choose Medicare as your primary group insurer only by canceling your enrollment in NYSHIP. *If you do so, there will be no further coverage for you and your dependents under NYSHIP. Your benefits will be drastically reduced with only Medicare coverage.* While you are an active employee, your spouse or other dependent who becomes eligible for

Medicare because of age or disability also may choose Medicare as primary insurer only by canceling enrollment in NYSHIP. *However, their benefits would be drastically reduced because no benefits would be available through NYSHIP.*

Exceptions: Medicare becomes primary for domestic partners at age 65 and for end stage renal disease

Domestic Partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare-eligible at age 65. The domestic partner must have Medicare Part A and Part B in effect when first eligible at 65. However, if the domestic partner becomes Medicare-eligible because of disability, NYSHIP remains primary.

Medicare end stage renal disease coordination: An active employee, or the dependent of an active employee, who develops **end stage renal disease** becomes eligible for primary Medicare coverage and **must** enroll in Medicare Parts A and B under the following circumstances:

Medicare imposes a three-month waiting period after a patient is diagnosed with end stage renal disease before Medicare becomes effective. However, Medicare waives this waiting period if the patient enrolls in a self-dialysis training program within the first three months of the diagnosis or receives a kidney transplant within the first three months of being hospitalized for the transplant.

If there is a waiting period at the onset of end stage renal disease before Medicare becomes effective, NYSHIP continues to be the primary insurer for the three-month waiting period.

After the three-month waiting period, Medicare begins to count a 30-month waiting period that the patient must satisfy before Medicare is primary. The three-month waiting period, if not waived, plus the 30-month waiting period, makes a total waiting period of 33 months.

During the waiting period, NYSHIP (or another employer's plan) continues to be the patient's primary insurer. At the end of the waiting period, Medicare becomes the patient's primary insurer and NYSHIP will be the patient's secondary coverage.

Since Medicare will provide only secondary benefits during the waiting period, NYSHIP does not require Medicare enrollment during this time and will not provide reimbursement for the Part B premium. At the end of the waiting period, when Medicare becomes the primary insurer, NYSHIP requires the patient to have Medicare in effect.

Notify your agency Health Benefits Administrator if you or your dependent is eligible for Medicare because of end stage renal disease. Once Medicare is primary, the State will reimburse you for the Medicare Part B premium, unless you or your dependent receives reimbursement from another source. Notify your agency Health Benefits Administrator if Medicare coverage for end stage renal disease ends; NYSHIP will again provide primary coverage for an active employee or the dependent of an active employee.

You and your dependents must have Medicare in effect when first eligible for Medicare coverage that is primary to NYSHIP

As soon as you or your covered dependent becomes eligible for Medicare coverage that pays primary to NYSHIP (because of end stage renal disease or domestic partner status), you or your covered dependent must be enrolled in Medicare Parts A and B. You must have it in effect and be entitled to receive Medicare benefits when first eligible even if you also have coverage through another employer's group plan. If you or a dependent is eligible for Medicare coverage that is primary to NYSHIP, but has failed to enroll when first eligible, you may have to pay for service you receive from your HMO.

Contact your HMO to find out how your HMO coordinates with Medicare:

- Under a Medicare+Choice Contract, you assign your Medicare benefits directly to the HMO. You will not receive any Medicare benefits if you choose to receive care outside your HMO.
- Under a Cost Contract or certain other arrangements, the HMO supplements your Medicare benefits. If you choose to receive treatment outside the HMO, you still qualify for Medicare benefits.

When an active employee is enrolled as a retiree's dependent

If an active State employee, age 65 or over, is enrolled in NYSHIP as the dependent of a retired spouse (rather than in his or her own right as an employee), the employee has "retiree" coverage in NYSHIP and must enroll in Medicare when first eligible. Medicare will pay primary to NYSHIP, and the retired spouse will be eligible to receive reimbursement for the Medicare Part B premium on behalf of the active employee, unless reimbursement is received from another source.

When you are no longer an active employee

When you are no longer an active State employee, NYSHIP or Medicare will be primary as follows:

Retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions and their dependents under age 65: NYSHIP continues to provide your primary coverage until you turn 65 or until you become eligible for Medicare due to disability, then Medicare becomes primary. If you develop end stage renal disease, NYSHIP will provide your primary coverage for the three-month waiting period plus the 30-month period described above; then Medicare becomes primary.

If you have Family coverage, NYSHIP will provide primary coverage for your covered dependents until they become eligible for primary Medicare coverage due to age, disability or end stage renal disease. If your spouse or other dependents are covered under other group health insurance, ask your HMO about primary coverage.

Retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions and their dependents age 65 or over: Medicare provides coverage that pays primary to NYSHIP. If your spouse is also age 65 or over, Medicare provides coverage that is primary to NYSHIP for him or her. Your spouse under age 65 and/or your other enrolled dependents may be eligible for primary Medicare coverage because of disability or end stage renal disease. You and your dependents must have Medicare Parts A and B in effect when first eligible.

If you are also covered by another employer's group plan

If you are no longer an active State employee and you have coverage under another employer's group plan, the order of claims payment is 1) current employer plan; 2) Medicare; and 3) NYSHIP.

When to enroll in Medicare

As an active State employee, contact Medicare immediately if you, your spouse or enrolled dependent is eligible for primary Medicare coverage due to end stage renal disease. Also, the domestic partner of an active State employee must have Medicare Part A and Part B in effect by the first of the month in which the domestic partner reaches age 65.

If you are planning to retire or otherwise leave State service, and you or your spouse is 65 or older, contact your Social Security office **three months before active employment ends** to arrange for Medicare Parts A and B. If you are 65 or over when you retire or otherwise leave State service, NYSHIP will no longer be your primary insurer beginning the first day of the month following a "runout" of 28 days after the last day of the last payroll period for which you were paid. Be sure you have Medicare in effect at that time.

Planning to retire: Avoid a gap in coverage

If you are planning to retire or otherwise leave State service and are under 65, Medicare becomes primary to NYSHIP on the first day of the month in which you reach age 65. Contact Social Security **three months before you reach age 65** to be sure of having Medicare in effect at that time.

Although Medicare allows you to enroll up to three months after your 65th birthday, NYSHIP requires you to have Medicare Parts A and B in effect on the first day of the month in which you reach 65. If you do not apply three months before your birthday, you will have a waiting period before Medicare becomes effective. During that waiting period, you will have a gap in your coverage that could be very costly for you.

Regardless of age, contact your Social Security office if you are planning to retire or otherwise leave State service and you or your spouse or dependent is disabled.

How to enroll

You can sign up for Medicare by telephone and mail. Contact your local Social Security office at 1-800-772-1213. Ask for a Teleclaim appointment. Information about applying for Medicare is also available on the Web at www.medicare.gov.

Medicare premium reimbursement

If you or your dependent is Medicare primary, the State will reimburse you for the usual (base) cost of "original" Medicare Part B monthly premiums ($58.70 per month in 2003) unless you are receiving reimbursement from another source. Retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions and COBRA enrollees who become Medicare primary at age 65 are reimbursed automatically. Domestic partners and enrollees who become Medicare primary before age 65 because of disability or end stage renal disease must apply for reimbursement.

Reimbursement for dependents not automatic

If your dependent is eligible for primary Medicare coverage (as described above for domestic partners and end stage renal disease), reimbursement for the dependent's Medicare Part B premium is not automatic. You must take a photocopy of your dependent's Medicare identification card to your agency Health Benefits Administrator. Be sure to include your name and identification number on the photocopy. If you are not an active employee, contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344.

Loss of eligibility for Medicare premium reimbursement

If you or a dependent loses eligibility for Medicare premium reimbursement (for example, you return to work for New York State in a benefits-eligible position, you move out of the country or your spouse dies), you must contact your agency Health Benefits Administrator or the Employee Benefits Division. You will be liable for premiums that are incorrectly reimbursed.

Medicare+Choice HMOs

As a retiree, be sure you understand that if you or your dependent enrolls in an HMO under a Medicare+Choice Contract, the Medicare+Choice HMO replaces your traditional Medicare coverage. You will not receive any Medicare benefits if you choose to receive care outside your HMO. In contrast, under a Medicare Cost Contract, or under supplemental arrangements, you still qualify for Medicare benefits if you choose to receive treatment outside your HMO. Ask the HMO for details of their plans for Medicare enrollees if you will be retiring and Medicare-eligible before the next Option Transfer Period.

Re-employment

If you return to active State employment in a benefits-eligible position, for example, from retirement, and meet the health benefits eligibility requirements for active employees, NYSHIP again provides primary coverage for you, your spouse and other enrolled dependents. Medicare is primary, however, for the domestic partner age 65 or over of an active employee, unless the domestic partner is disabled.

When to contact your agency Health Benefits Administrator

At the time of your re-employment, ask your agency Health Benefits Administrator to arrange to notify the Empire Plan carriers or your HMO of your re-employment. Be sure to find out the effective date for your NYSHIP plan to resume providing coverage that is primary to Medicare.

Keeping Your Coverage Up To Date

To keep your coverage up to date, you must notify your agency Health Benefits Administrator if...

Your home address changes (Also notify your HMO)

Your phone number changes (Also notify your HMO)

Your name changes (Also notify your HMO)

Your family unit changes

- You marry or divorce; your domestic partner no longer qualifies
- You want to add a dependent
- You no longer have any eligible dependents
- Your dependent loses eligibility
- You no longer wish to provide coverage for a dependent
- You have a disabled dependent
- Your spouse dies

Your employment status changes

- You are going to retire from State service
- You are affected by layoff
- You are going on leave without pay
- You are going on Family and Medical Leave
- You want to continue your health insurance coverage while in vested status
- You have questions about continuing coverage under COBRA
  (To apply for COBRA, write to the Employee Benefits Division within 60 days after NYSHIP coverage ends.)

You have questions about NYSHIP

- You have questions concerning your family's eligibility for health insurance coverage
- You have questions about changing your type of coverage (Family/Individual)
- You have questions about changing your health insurance option; you would like information about other NYSHIP HMOs and the Empire Plan
- You or a covered dependent becomes eligible for Medicare benefits because of end stage renal disease or because your domestic partner will be 65 soon
- You want to know how to coordinate your NYSHIP benefits with Medicare
- You have questions about the Pre-Tax Contribution Program
- You do not want to participate in the Pre-Tax Contribution Program

Other

- You become disabled and want to apply for a waiver of premium
- You want to cancel your health insurance coverage to obtain dependent status under your spouse's NYSHIP coverage
- You want to cancel your coverage
  (Notify the Employee Benefits Division in writing if you want to cancel your COBRA coverage.)
- You return to State service

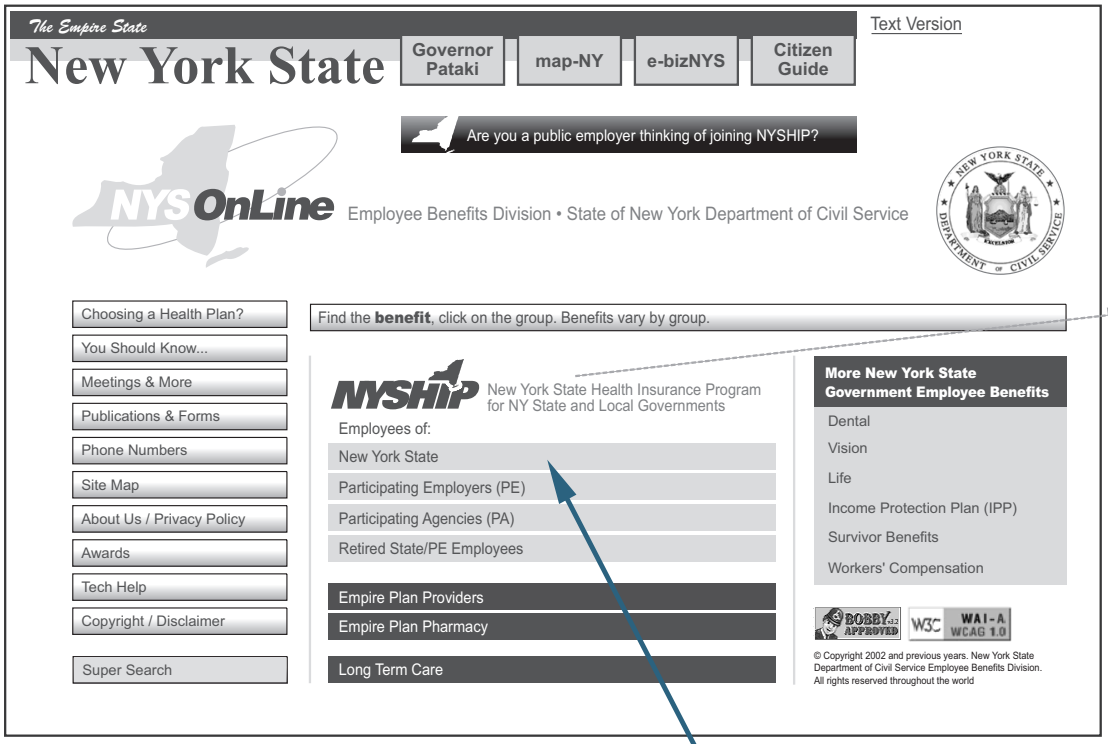
You may write or call:

Health Benefits Administrator
Human Resources Office
NYS Division of State Police
State Campus Building 22
1220 Washington Avenue
Albany, New York 12226
518-457-6082

Visit us on the Web at www.cs.state.ny.us

Check our New York State Department of Civil Service Employee Benefits Division Web site at www.cs.state.ny.us. Click on Employee Benefits for timely information about your NYSHIP benefits. Publications are available on our site, which meets universal accessibility standards adopted by New York State for NYS Agency Web sites.

If you don't have access to the Internet, visit your local library. Most libraries have computers linked to the Internet.



Health Insurance
Choose your group to go to *"NYSHIP General Information Book"* for information about NYSHIP

Look for your NYSHIP benefits here

Click on PIA

Notes

Notes

Notes

Important Telephone Numbers

Agency Health Benefits Administrator 518-457-6082
You must keep your coverage up to date. Call to report that your child, age 19 or over, is no longer a student, to delete a dependent, to add a dependent, to report your address change, to ask about NYSHIP rules for enrolling in COBRA or Medicare. Call if you followed your HMO's appeals procedure but you and your HMO do not agree about covered benefits; under New York State Insurance Law, you have 45 days to request an External Appeal if your HMO service is denied on the basis that the service is not medically necessary or is an experimental or investigational treatment.

COBRA Enrollees: The Employee Benefits Division at **518-457-5754 (Albany area) or 1-800-833-4344** serves as your Health Benefits Administrator.

Your NYSHIP HMO....._____**.....**_____
fill in name of HMO fill in telephone number

Call for benefits information, lists of providers, replacement identification cards, prescription drug information, converting to a direct-pay contract, coordinating with Medicare.

SAVE THIS BOOK

IMPORTANT INFORMATION ABOUT THE NEW YORK STATE HEALTH INSURANCE PROGRAM

This book is for the BCI Unit of the New York State Police represented by the Police Investigators Association and enrolled in NYSHIP HMOs. It combines the April 1, 1999 *NYSHIP General Information Book* for PIA and later *HMO Reports/NYSHIP Changes*.

Updates to this book will be mailed to you if benefits change. Keep all updates with this book.

Benefit changes that are mailed to you will also be posted on our Web site, www.cs.state.ny.us. Click on Employee Benefits.

It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the Department of Civil Service Web site (www.cs.state.ny.us). Click on Employee Benefits for timely information that meets universal accessibility standards adopted by New York State for NYS Agency Web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA enrollees may call the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands.)

GIB-HMO/PIA/4-03

State of New York
Department of Civil Service
Employee Benefits Division
The State Campus
Albany, New York 12239
www.cs.state.ny.us

Address Service Requested

NYSHIP
New York State Health Insurance Program

Important. Health Insurance Information
For the Enrollee, Enrolled Spouse/Domestic Partner and Other Enrolled Dependents

PIA HMO Book - April 2003

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