

— 2016 —
**GENERAL
INFORMATION
BOOK**

Participating Employers

New York State Health Insurance Program

General Information Book for Employees, Retirees, Vestees and Dependent Survivors enrolled in NYSHIP through Participating Employers, their enrolled Dependents, Preferred List and COBRA enrollees and Young Adult Option enrollees with their Empire Plan benefits

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



NYSHIP
New York State
Health Insurance Program

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Introduction

This is the *New York State Health Insurance Program (NYSHIP) General Information Book* for individuals enrolled in NYSHIP through a NYSHIP Participating Employer (PE) and their covered dependents. It includes information about NYSHIP rules and provisions.

This book provides general information about eligibility, enrollment and other NYSHIP rules and provisions that your employer must follow. For specific information that applies to you, speak to your Health Benefits Administrator (active employees) or the Employee Benefits Division (retired enrollees, vestees, dependent survivors, enrollees in Preferred List status). Your employer may establish criteria consistent with NYSHIP parameters, such as your share of the cost of NYSHIP coverage, how long you must work with the employer to be eligible for retiree coverage (if you are eligible) and when your benefits go into effect. This is not an inclusive list of criteria.

About This Book

This book explains certain rights and responsibilities you have as an enrollee in NYSHIP. Receipt of this book does not guarantee you are eligible for or enrolled in coverage.

This book has two sections. The first section, beginning on page 2, applies to active employees. The second section, beginning on page 42, applies when you are no longer working for the employer that provides you with your NYSHIP coverage, such as when you are covered as a retiree, vestee, dependent survivor, dependent of an enrollee who is no longer an active employee or as an enrollee in Preferred List status (Preferred List applies only to former employees who have been laid off).

Be sure you refer to the appropriate section of the book for information.

NYSHIP is established under New York State Civil Service Law. The Department of Civil Service (DCS) is responsible for administering NYSHIP and determines NYSHIP's administrative policies, practices and procedures. NYSHIP rules, requirements and benefits are established in accordance with applicable federal and state laws. NYSHIP provisions negotiated with State employee unions may be administratively extended to Participating Employers. NYSHIP rules, requirements and benefits also may be affected by court decisions.

Therefore, the information in this book is subject to change, and you will be notified of changes through mailings to your address (on your NYSHIP record). Please make sure that your Health Benefits Administrator or the Employee Benefits Division has your most current address. Amendments and notification of changes also can be found on the Department's web site, www.cs.ny.gov.



General Information Book

For Active Employees of Participating Employers

Refer to this portion of the book for information if you are still actively employed by a NYSHIP Participating Employer, including if you are receiving NYSHIP benefits while you are on a leave of absence.

After you have retired or separated from service with a NYSHIP Participating Employer, refer to the second part of this book, pages 42-74, for information.

When You Need Assistance

Your Health Benefits Administrator, usually located in your personnel office, is responsible for managing your enrollment record and providing you with information about your employer's rules and requirements regarding your NYSHIP eligibility and enrollment.

Empire Plan inquiries: For questions on specific benefits or claims, or to locate a provider, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate program.

HMO inquiries: For questions on specific benefits or HMO services, or to locate a provider, call your HMO.

You are responsible for letting your Health Benefits Administrator know of any changes that may affect your NYSHIP coverage.

When You Must Contact Your Health Benefits Administrator

To keep your enrollment up to date, you must notify your Health Benefits Administrator in writing in the following situations:

Your mailing address changes or your home address changes (If you or a dependent is Medicare primary and your mailing address is a P.O. Box, your Health Benefits Administrator will need your current residential address as well.)

Your phone number changes

Your name changes

You need to correct your enrollment record

Your family unit changes (see *Dependent Eligibility*, page 7 for details)

- You want to add or remove a covered dependent or change your type of coverage (Individual/Family)
- Your covered dependent loses eligibility
- Your covered dependent child becomes disabled
- You get divorced
- The enrollee or a dependent dies (a copy of the death certificate must be submitted)

Your employment status is changing

- You are planning to retire
- You are going on leave without pay or Family and Medical Leave
- You are leaving employment prior to retirement
- You are affected by layoff
- You are returning to work for the same Participating Employer that provides your NYSHIP benefits as a retiree
- You are awarded a disability retirement

Your Medicare status is changing

- You or a covered dependent becomes eligible for Medicare benefits (See *Medicare and NYSHIP*, page 36)
- You or a covered dependent loses eligibility for Medicare

Other reasons to contact your Health Benefits Administrator

- Your employee benefit card is lost or damaged
- You have questions about the amount of your premium or your bill for NYSHIP coverage

- You want to cancel or reinstate your coverage
- You have questions about Consolidated Omnibus Reconciliation Act (COBRA) continuation of coverage; see *COBRA: Continuation of Coverage*, page 23

Benefits on the Web

You'll find NYSHIP Online, the NYSHIP homepage, on the New York State Department of Civil Service web site at www.cs.ny.gov/employee-benefits. Copies of NYSHIP documents and informational materials are available on NYSHIP Online, and Empire Plan enrollees will find links to Plan administrator web sites, which include the most current lists of participating providers.

Your Options Under NYSHIP

To enroll in NYSHIP, you will need to choose one of the following options:

- The Empire Plan
- a health maintenance organization (HMO) that has been approved for participation in NYSHIP in the geographic area where you live or work

Your Participating Employer may elect to offer only The Empire Plan or it may elect to offer both The Empire Plan and NYSHIP HMOs. Additionally, your employer may offer health plans outside of NYSHIP. Contact your Health Benefits Administrator for information about available health plan options.

For details about The Empire Plan and NYSHIP HMOs, refer to the *Choices* booklet, issued annually, usually in November or December. You may obtain a copy of *Choices* from your Health Benefits Administrator, usually located in your personnel office.

The Empire Plan or a NYSHIP HMO

Regardless of whether you choose The Empire Plan or a NYSHIP HMO, your coverage provides you and your eligible dependents with all of the following:

- hospitalization and related expense coverage
- medical/surgical care coverage
- mental health and substance abuse treatment coverage
- prescription drug coverage

HMOs approved for participation in NYSHIP are not available in all areas. To enroll or continue enrollment in a NYSHIP HMO, you must live or work in that HMO's service area. If you no longer meet the requirements of living or working in that NYSHIP HMO's service area, you will have to change options. The benefits provided by The Empire Plan and the HMOs differ. Be sure to choose the option that best meets your needs.

You and your dependents will have the same option. You, the enrollee, will determine the option for you and your covered dependents.

Annual Option Transfer Period

During the annual Option Transfer Period, usually in November or December, you may change to any NYSHIP option for which you are eligible for any reason.

There is no open enrollment period. If you and/or your dependents were previously eligible for NYSHIP coverage and declined coverage when it was first offered but then later decided to enroll, you must satisfy the late enrollment waiting period before coverage begins.

Each year, you will be mailed a document called “Option Transfer Information,” which will notify you of the Option Transfer Period dates. Check deadlines and carefully read the information you receive. You may also receive Option Transfer information from your agency.

To change options during the Option Transfer Period, see your Health Benefits Administrator. If you change options, your Health Benefits Administrator will inform you of the date the new coverage will begin and the cost for that coverage.

Qualifying Life Events: Changing Your NYSHIP Option outside the Option Transfer Period

If your Participating Employer offers both The Empire Plan and HMOs, you may change options outside the designated Option Transfer Period only if:

- You are no longer eligible to continue coverage in your current HMO because you move permanently out of your current HMO’s service area or your job’s location changes and is no longer located in your current HMO’s service area. To keep NYSHIP coverage, you must choose The Empire Plan or a different HMO that serves your new area.
- You move permanently or your job’s location changes and you want to change to an HMO that was not available where you previously lived or worked. You may change to the newly available HMO regardless of what option you were in before you moved.
- Your dependent moves permanently and is no longer in your HMO’s service area. (**Note:** A student attending college outside your HMO’s service area is not considered a change in permanent residence.)
- You add a newly eligible dependent to your coverage in a timely manner (see pages 12-13 for time frames). The dependent may be acquired through marriage, domestic partnership, birth, adoption, placement for adoption or if your child meets the “other” child eligibility criteria (see page 8).
- You return to your employer’s payroll after military leave.
- You return to your employer’s payroll after a break in State service, if you were ineligible to continue enrollment during the break.
- You return to your employer’s payroll after going on leave without pay and an Option Transfer Period occurred while you were on leave. You may select any option when you reenroll.
- You retire or vest your health insurance.

All requests to change options must be made in a timely manner, typically within 30 days of your qualifying life event, to ensure you have continued access to benefits.

To change your option when you retire or vest coverage, see your Health Benefits Administrator before you leave the payroll.

Examples of requests that do not qualify for a change outside of the Option Transfer Period include, but are not limited to:

- Your doctor is no longer participating in your current plan’s network, so you want to change to a plan with a network that includes your doctor.
- Your current plan does not cover a procedure you need, so you want to change to a plan that does cover the procedure.
- You experience a change in your health and need to take new medications, so you want to change to an option with lower out-of-pocket prescription drug costs.
- Your financial situation changes, so you want to enroll in a less expensive option.
- Your child is attending college outside your HMO’s service area, so you want to change to an option with a network in your child’s area.

Consider Carefully

Be sure you understand how your benefits will be affected by changing options. By changing options, you could be getting substantially different coverage.

Employee Eligibility

Minimum eligibility requirements for coverage are established by New York State law. Participating Employer eligibility requirements may exceed NYSHIP minimum eligibility requirements, as described in this section. For information about your employer's specific eligibility requirements, contact your Health Benefits Administrator.

When first eligible for coverage, you may be subject to a waiting period (not to exceed 90 days) before coverage begins.

If you do not enroll when first eligible, you will be subject to a late enrollment waiting period (see "When Coverage Begins," page 14).

To be eligible for NYSHIP coverage, you must meet all of the following requirements:

- You must be appointed/elected to a benefits-eligible position with a NYSHIP Participating Employer.
- You must 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 any waiting period established by your employer, including days worked before your leave began.

In addition, employers may adopt or expand on certain requirements, as shown in the table below.

Eligibility Requirements for Coverage

NYSHIP requires you to meet all of the following criteria to be eligible for coverage:

1. You are expected to work at least three months. (**Note:** This requirement does not apply to paid elected officials.)
2. You work a regular schedule of 20 hours or more per week; **or**
are paid an annual salary at a rate of \$2,000 or more per year; **or**
meet one of the following criteria:
 - are a local elected official
 - are a paid member of a public legislative body
 - are an unpaid board member of a public authority with at least six months' service as a board member

or

 - the major source of your family's income is from your public employment.
3. You are not already enrolled in NYSHIP as the result of your current or former employment.

In addition to NYSHIP's minimum eligibility requirements, your agency may require:

- a longer anticipated term of employment. However, your employer cannot require that your employment be anticipated to be a term greater than six months; **or**
- a regular schedule of more than 20 hours per week; **or**
- a required minimum annual salary of more than \$2,000 per year; **or**
- work week or annual salary eligibility requirements for local elected officials, paid members of public legislative bodies or elected members of school boards.

Employer discretion based on class or category of employee

Your employer may determine which classes or categories of employees are eligible for NYSHIP coverage. (For example, a Participating Employer may offer NYSHIP coverage to active employees, but not retirees). Eligibility may be established through collective bargaining agreements or administratively by your employer.

Dual Coverage in NYSHIP

NYSHIP prohibits dual coverage as the enrollee. If you are already enrolled in NYSHIP as an employee or retiree, you cannot enroll again through a different employer as an employee or retiree. You must choose which employer you wish to be enrolled through.

Example: Bob is a retiree of New York State. After retiring, he takes a benefits-eligible job at a NYSHIP Participating Employer. Bob is eligible to be enrolled in NYSHIP as a retiree of New York State or as an employee through his position with the Participating Employer. Bob cannot enroll as both, so he must choose the employer through which he would like coverage.

Note: You can have dual NYSHIP coverage if you are covered as the enrollee and also as a dependent (see *Coverage: Individual or Family*, page 11). However, New York State does not permit two Family coverages. If one spouse is enrolled as an employee of New York State, only one spouse may elect Family coverage. The other spouse may only elect Individual coverage).

Example: Both Bob and his spouse, Linda, are eligible for NYSHIP as the result of their active employment. Bob works for Public Authority A and Linda works for Public Authority B. Bob may be covered by his employer (Public Authority A) as an enrollee and also as Linda's NYSHIP dependent (by Public Authority B).

Dependent Eligibility

You may cover your eligible dependents under NYSHIP by enrolling in Family coverage or adding eligible dependents to existing Family coverage. The dependents meeting the requirements described in this section are eligible for NYSHIP coverage.

To enroll your dependent who is eligible for NYSHIP but not enrolled, contact your Health Benefits Administrator.

See *Proof of Eligibility* on page 10 for required proofs that must be submitted with the request to add a dependent to your coverage.

For information about when your dependents' coverage will take effect, see pages 12-14.

Note: Enrollees covered under the Young Adult Option are eligible for Individual coverage only; they may not cover their dependents. Refer to *Young Adult Option* on page 40 for information about eligibility under this option.

Your Spouse

Your spouse, including a legally separated spouse, is eligible for NYSHIP coverage. 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.

Your Domestic Partner

Rules for domestic partners or children of domestic partners in this book apply only if that coverage is offered by your employer. If your employer does not offer coverage to domestic partners, your domestic partner is not eligible to be covered as your dependent under NYSHIP. Your domestic partner's child(ren) also may not be eligible, unless eligible as "other" children (see "Your 'other' child" below). Ask your Health Benefits Administrator if your employer offers coverage to domestic partners.

If your employer does offer coverage to domestic partners, you may cover your domestic partner as your dependent. For eligibility under NYSHIP, a domestic partnership is one in which you and your partner are able to certify that you:

- are both 18 years of age or older,
- have been in the partnership for at least six months,
- are both unmarried (copy of divorce decrees or death certificate(s) required, if applicable),
- are not related in a way that would bar marriage,
- have shared the same residence and have been financially interdependent for at least six months and
- have an exclusive mutual commitment (which you expect to last indefinitely) to share responsibility for each other's welfare and financial obligations.

To enroll a domestic partner, you must complete and return the forms *Application for Domestic Partner Benefits* (PS-425.1) and *Dependent Tax Affidavit for Domestic Partners* (PS-425.3) and submit the applicable proofs as outlined on the *Application for Domestic Partner Benefits*. Before a new domestic partner may be enrolled, you will be subject to a one-year waiting period from the termination date of your last domestic partner's coverage.

Under Internal Revenue Service (IRS) rules, the fair market value cost of coverage for a domestic partner may be taxable. This amount, referred to as imputed income, is considered by the IRS to be additional income for the enrollee. Check with your Health Benefits Administrator to find out how imputed income is reported and for an approximation of the fair market value for domestic partner coverage. You may also ask a tax consultant how enrolling a domestic partner will affect your taxes.

Your Children

The following children are eligible for coverage until age 26:

- your natural child
- your stepchild
- your domestic partner's child (if domestic partner coverage is offered by your employer)
- your legally adopted child, including a child in a waiting period prior to finalization of adoption
- your "other" child

Your "other" child

You may cover "other" children:

- who are financially dependent on you
- who reside with you
- for whom you have assumed legal responsibility in place of the parent

The above requirements must be reached before the "other" child is age 19. You must file the form *Statement of Dependence* (PS-457), verify eligibility and provide documentation upon enrollment and every two years thereafter.

Your disabled child

You may cover your disabled child who is age 26 or older if the child:

- is unmarried
- is incapable of self-support by reason of mental or physical disability
- acquired the disabling condition before he or she would otherwise have lost eligibility due to age

Contact your Health Benefits Administrator prior to your child's 26th birthday (or 19th birthday for an "other" child with disability) to begin the review process. To apply for coverage for your disabled child, you must submit the form *Statement of Disability* (PS-451) and provide medical documentation. You will be asked to complete the *Statement of Disability* form and provide medical documentation to certify the child's disability (at minimum) every seven years (frequency based on disabling condition). If a disabled dependent is also an "other" child, you will be required to resubmit the form *Statement of Dependence* (PS-457) every two years (at minimum).

Your child who is a full-time student with military service

For the purposes of eligibility for health insurance coverage as a dependent, you may deduct from your child's age up to four years for service in a branch of the U.S. Military for time served between the ages of 19 and 25. To be eligible, your dependent child must:

- return to school on a full-time basis,
- be unmarried and
- not be eligible for other employer group coverage.

You must be able to provide written documentation from the U.S. Military showing the dates of service. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required for verification.

Example: *Rebecca is 27 years old and served in the military from ages 19 through 23, then enrolled in college after four years of military service. After deducting the four years of military service from her true age, her adjusted eligibility age is 23 (even though Rebecca is actually 27). As long as Rebecca remains a full-time student, she is entitled to be covered as a dependent until her adjusted eligibility age equals 26. In this example, Rebecca can be covered as a dependent for an additional three years, and when she reaches the adjusted eligibility age of 26, her actual age will be 30.*

In no event will any person who is in the armed forces of any country, including a student in an armed forces military academy of any country, be eligible for coverage.

Proof of Eligibility

Your application to enroll or to add a dependent to your coverage will not be processed by your Health Benefits Administrator without required proof of eligibility. Refer to *Employee Eligibility* (page 6) and *Dependent Eligibility* (page 7) for eligibility requirements.

Required Proofs

You must provide the following proofs to your Health Benefits Administrator:

You, the enrollee

- birth certificate
- Social Security card
- Medicare card (if applicable)

Spouse*

- birth certificate
- marriage certificate
- proof of current joint ownership/joint financial obligation (if the marriage took place more than one year prior to the request for coverage)
- Medicare card (if applicable)

Domestic partner**

- birth certificate
- completed forms in the *Domestic Partner Series* (PS-425) with appropriate proof as required in the application
- Medicare card (if applicable)

Natural-born children, stepchildren and children of a domestic partner**

- birth certificate
- Medicare card (if applicable)

Adopted children*

- adoption papers (if adoption is pending, proof of pending adoption)
- birth certificate
- Medicare card (if applicable)

Your disabled child over age 26*

- birth certificate
- completed form *Statement of Disability* (PS-451) with appropriate documentation submitted to, and approved by, the NYSHIP plan administrator
- Medicare card (if applicable)

“Other” children*

(For more information about who qualifies as an “other” child, please refer to the section “Your Children” in *Dependent Eligibility*, page 8.)

- birth certificate
- completed form *Statement of Dependence* (PS-457) with appropriate documentation as required in the application
- Medicare card (if applicable)

Your child who is a full-time student over age 26 with military service*

- birth certificate
- adoption papers (if applicable)
- Medicare card (if applicable)
- written documentation from the U.S. Military showing dates of active service
- proof of full-time student status from an accredited secondary or preparatory school, college or educational institution

* Provide the Social Security numbers of dependents when enrolling them for coverage.

** Not all employers offer coverage to domestic partners (see *Dependent Eligibility*, page 7). Contact your Health Benefits Administrator for information.

Providing false or misleading information about eligibility for coverage or benefits is fraud.

Coverage: Individual or Family

Two types of coverage are available to you under NYSHIP: Individual coverage for yourself only or Family coverage for yourself and any eligible dependents you choose to cover.

Note: Young Adult Option enrollees are only eligible for Individual coverage.

Individual Coverage

Individual coverage provides benefits for you. It does not cover your dependents, even if they are eligible for coverage.

If you do not enroll when first eligible, you may be subject to a late enrollment waiting period. Refer to “Effective date of coverage” in *Enrollment* on page 14 for more information.

Family Coverage

Family coverage provides benefits for you and any eligible dependents you elect to enroll. For more information on who can qualify as your dependent, see *Dependent Eligibility*, page 7.

If you and your spouse are both eligible for coverage under NYSHIP, you may elect one of the following:

- one Family coverage
- two Individual coverages
- one Family coverage and one Individual coverage
- two Family coverages, if both of your employers permit two Family coverages (**Note:** New York State does not permit two Family coverages. If one spouse is enrolled as an employee of New York State, only one spouse may elect Family coverage. The other spouse may only elect Individual coverage).

Changing Coverage

Changes in enrollment and a pre-tax contribution program

Enrollment in a pre-tax contribution program limits changes to your pre-tax health insurance deduction for the current plan year. If your employer offers a pre-tax contribution program, and you are considering changing your type of coverage, contact your Health Benefits Administrator regarding possible restrictions to changes in your health insurance premium deduction.

Changing from Individual to Family coverage

If you are changing to Family coverage because you acquired a new dependent (for example, you married), your new coverage will begin according to when you apply. **Note:** The time frame for covering newborns is different (see “Covering newborns”).

If you are changing to Family coverage to add a dependent who was previously eligible but not enrolled, Family coverage will begin on the first day of the third month following the month in which you apply.

If you wish to change from Individual to Family coverage (and your dependent meets the requirements in *Dependent Eligibility*, page 7), contact your Health Benefits Administrator. Be prepared to provide the following:

- your name, Social Security number, address and phone number
- the effective date and reason you are requesting the change (see the following for more information)
- your dependent’s name, date of birth and Social Security number
- a copy of the Medicare card, if a dependent is eligible for Medicare

Additional documentation will be required. See *Proof of Eligibility* on page 10.

First Date of Eligibility

The first date of eligibility for a dependent is the date on which an event took place that qualified the individual for dependent coverage (for example, the date of marriage or a newborn’s date of birth).

The date your dependent’s coverage begins will depend on your reason for changing coverage and your timeliness in applying. You can avoid a waiting period by applying promptly.

You may change from Individual to Family coverage as a 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 the following section, “Covering newborns”).
- Your dependent’s other health insurance coverage ends.
- You return to the payroll after military leave and you want to cover dependents acquired during your leave.

Your dependents’ coverage will begin according to when you apply. If you apply:

- **7 days or less after a dependent’s first date of eligibility**, your Family coverage will be effective on the date the dependent(s) was first eligible.
- **8–30 days after a dependent’s first date of eligibility**, there will be a waiting period. Family coverage will begin on the first day of the month following the month in which your request is made.
- **more than 30 days after a dependent’s first date of eligibility**, there will be a longer waiting period. Your Family coverage will become effective on the first day of the third month following the month in which you apply. If you apply on the first day of the month, that month is counted as the first month of the waiting period.

Covering newborns

Your newborn child is not automatically covered; you must contact your Health Benefits Administrator to complete the appropriate forms. For additional documentation that may be needed, refer to *Proof of Eligibility* on page 10.

If you want to change from Individual to Family coverage to cover a newborn child and you request this change within 30 days of the child's birth, the newborn's coverage will be effective on the child's date of birth.

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 in order for the coverage to be effective on the day the child was born.

If you already have Family coverage, you must also remember to add your newborn child within 30 days or you may encounter payment delays.

Adding a previously eligible dependent to existing Family coverage

To add a previously eligible but not yet enrolled dependent to your existing Family coverage, contact your Health Benefits Administrator. Your previously eligible dependent's coverage will begin based on the timelines outlined in "Changing from Individual to Family coverage" on page 12.

Changing from Family to Individual coverage

It is your responsibility to keep your enrollment record up to date. If you no longer have any eligible dependents, you must change from Family to Individual coverage. You also may be able to make this change if you no longer wish to cover your dependents, even if they are still eligible.

Refer to the section *End Dates for Coverage*, page 22, for information about when your dependent's coverage ends if you change from Family to Individual coverage, or contact your Health Benefits Administrator. For information about continuing coverage, see *COBRA: Continuation of Coverage* on page 23 and *Young Adult Option* on page 40, or contact your Health Benefits Administrator.

Enrollment Considered Late if Previously Eligible

If you or your dependent was previously eligible but not enrolled, coverage will begin on the first day of the third month following the month in which you apply.

Exception: Dependents affected by National Medical Support Order

If a National Medical Support Order requires you to provide coverage to your previously eligible but not enrolled dependent(s), the late enrollment waiting period is waived and coverage for your dependent(s) will be effective on the date indicated on the National Medical Support Order. You must contact your Health Benefits Administrator and provide all of the following:

- a copy of the court order
- supporting documents showing that the dependent child is covered by the order
- supporting documents showing that the dependent child is eligible for coverage under NYSHIP eligibility rules (see *Proof of Eligibility*, page 10)

Exception: Changes in Children's Health Insurance Program (CHIP) or Medicaid eligibility

An employee or eligible dependent has special rights to enroll in NYSHIP if:

- coverage under a Medicaid plan or CHIP ends as a result of loss of eligibility or
- an employee or dependent becomes eligible for employment assistance under Medicaid or CHIP.

NYSHIP coverage must be requested within 60 days of the date of the change to avoid a waiting period.

Enrollment

Enrollment is Not Automatic

If you are eligible for NYSHIP, you will not be covered automatically. To apply for coverage, you must submit a completed and signed *Health Insurance Transaction Form (PS-404)* and required proofs of eligibility to your Health Benefits Administrator.

To have coverage in effect on your first date of eligibility for coverage (see below), be sure to submit the form before that date. You will also need to submit required proofs of eligibility to your Health Benefits Administrator. If you choose a NYSHIP HMO, the HMO may require you to file an additional form.

If you do not apply when first eligible for coverage, you will be considered a late enrollee and will be subject to a waiting period before coverage is effective (see below).

When Coverage Begins

Your employer establishes the date on which you can be covered under NYSHIP. Your first date of coverage may be as early as the first day of employment, or up to a maximum of 90 days later. Ask your Health Benefits Administrator for your first date of eligibility.

Example 1: *Your employer has established a rule stating that the date an employee's coverage becomes effective is the first of the month following the employee's hire date. If you are hired on September 10, your first date of coverage is October 1.*

Example 2: *After working in a part-time capacity (10 hours per week) for several years, your employer increases your hours to 37 hours per week, effective November 25, which makes you eligible to enroll in NYSHIP. Your employer has established a rule stating that the date an employee's coverage becomes effective is the first day of the third month after the date an employee becomes eligible for NYSHIP coverage. Your first date of coverage is February 1.*

Effective date of coverage

Once your date of eligibility has been established, your new coverage becomes effective according to when you apply. If you apply:

- on or before the first date of eligibility for coverage, your coverage will be effective on the first date of eligibility for coverage.
- within 30 days after the first date of eligibility for coverage, your coverage will be effective on the first day of the month following the month in which you applied.
- more than 30 days after the first date of eligibility for coverage, your coverage will be effective on the first day of the third month following the month in which you applied.

Enrolling a Dependent

If you choose to enroll in Family coverage when you enroll in coverage for yourself, the effective date of your dependent's coverage will be the same as the effective date of your coverage.

If you already have Family coverage and apply to cover a dependent who is not currently enrolled, the effective date of your dependent's coverage will depend upon your timeliness in applying (see page 12 for time frames).

If you are changing from Individual to Family coverage to cover an eligible dependent, refer to "Changing from Individual to Family coverage," page 12, in *Coverage: Individual or Family*.

If your dependent is eligible for NYSHIP, but not enrolled, you must submit a completed and signed *Health Insurance Transaction Form (PS-404)* to your Health Benefits Administrator to apply for coverage. Refer to *Proof of Eligibility*, page 10, for documentation that will be required upon enrollment.

Reenrolling a dependent

A dependent who loses eligibility can be covered under NYSHIP if eligibility is restored. An unmarried, disabled dependent child who lost eligibility because he or she was no longer disabled can again be covered under NYSHIP if the same disability that qualified him or her as a disabled dependent while previously enrolled in NYSHIP again renders him or her incapable of self-support. Appropriate documentation will be required.

No Coverage during Waiting Period

Medical expenses incurred or services rendered during a waiting period (while you/your dependents are waiting for coverage to be effective) will not be covered.

Canceling Enrollment

To cancel your enrollment in NYSHIP, contact your Health Benefits Administrator.

If you die while your coverage is canceled, your dependents will have no rights to continue coverage as dependent survivors, under COBRA or through a direct-pay contract.

If you cancel your enrollment while you are in vestee status, you will not be eligible to reenroll in NYSHIP as a vestee or later on as a retiree unless you have maintained continuous NYSHIP coverage elsewhere.

Canceling coverage for your enrolled dependent(s)

If your enrolled dependent is no longer eligible for NYSHIP coverage, or you wish to cancel coverage for an enrolled dependent, contact your Health Benefits Administrator. Your dependent may be eligible to continue coverage under COBRA (page 23), the Young Adult Option (page 40) or a direct-pay contract (page 27).

Your Share of the Premium

Payment of premium does not establish eligibility for NYSHIP benefits. You must also meet NYSHIP eligibility requirements.

Employees

NYSHIP requirements establish a minimum contribution rate employers must make toward coverage for their employees. For Individual coverage, your employer must contribute a minimum of 50 percent of the premium. For Family coverage, your employer must contribute a minimum of 50 percent of your premium as the enrollee, plus 35 percent of the additional cost of dependent coverage. Your employer may contribute more toward the premium. Ask your Health Benefits Administrator what your contribution rate will be for NYSHIP coverage.

Unpaid elected officials

If you are not barred by statute from receiving compensation, you may be eligible for employer contributions toward the cost of your NYSHIP coverage. Contact your Health Benefits Administrator for information.

Dependent Survivors

Participating Employers are only required to contribute to the cost of dependent survivor coverage in certain situations. Refer to *Dependent Survivor Coverage* on page 20 and contact your Health Benefits Administrator for information.

COBRA Enrollees

Your employer is not obligated to contribute toward the cost of your premium, and as a COBRA enrollee, you may be responsible for paying both the employer and employee shares of the premium as well as a two percent administrative fee. Refer to *COBRA: Continuation of Coverage* on page 23 for information.

Young Adult Option Enrollees

There is no employer contribution toward the cost of coverage. Young Adult Option enrollees pay both the employer and employee shares of the premium. Refer to *Young Adult Option* on page 40 for information.

Identification Cards

Empire Plan Enrollees

Upon enrollment in The Empire Plan, you will receive one or more NYSHIP Empire Plan cards (depending on whether you enroll in Individual or Family coverage). The cards will be sent to the address on your enrollment record. These cards include your name and the names of your covered dependents (refer to page 75 of the *Appendix* for an example of your benefits card). Use these cards as long as you remain enrolled in NYSHIP. There is no expiration date on your card. A separate card will be mailed to any dependent with a different address on your enrollment record.

Present your NYSHIP Empire Plan card before you receive services, supplies or prescription drugs.

Your Empire Plan Medicare Rx card

If you or a dependent is enrolled in Empire Plan Medicare Rx, each person enrolled in Empire Plan Medicare Rx will receive a separate card for prescription drugs. Use this card whenever filling a prescription. (See “Empire Plan Medicare Rx” in *Medicare and NYSHIP* in the second part of this book, page 61.)

Ordering a card

Ask your Health Benefits Administrator to order a NYSHIP benefit card if your or a dependent’s card is lost or damaged. Your replacement card will be sent to the address on your enrollment record. At the time you request a replacement card, please confirm with your HBA that the address on your enrollment record is correct.

If you need to reorder an Empire Plan Medicare Rx card, call the Prescription Drug Program and follow the prompts for Empire Plan Medicare Rx (see *Contact Information*, page 90).

HMO Enrollees

Upon enrollment in a NYSHIP HMO, you will receive a NYSHIP HMO card. If you or your dependent becomes Medicare primary, you or your dependent may receive a new card. You may also receive an additional prescription drug card. If you have any questions concerning your card, including how to order a new one, contact your HMO.

Possession of a Card Does Not Guarantee Eligibility

Do not use your card before coverage becomes effective or after eligibility ends. To verify eligibility dates, contact your Health Benefits Administrator. Use of a benefit card when you are not eligible may constitute fraud. If you or a dependent uses the card when you are not eligible for benefits, you will be billed for all claims paid incorrectly on behalf of yourself or your dependents.

You are responsible for notifying your Health Benefits Administrator immediately when you or your dependents are no longer eligible for NYSHIP coverage.

How Employment Status Changes May Affect Coverage

Changes in your payroll status may affect your enrollment. If your employment status is changing, contact your Health Benefits Administrator for information about how your health insurance coverage, the cost of your coverage and how you pay your premium will be affected.

Changes that May Affect Coverage

- leaves of absence, such as leave with or without pay, leave under the Family and Medical Leave Act (FMLA) or military leave
- layoff
- reduction in hours
- termination of employment

Leaves of Absence that May Affect Coverage

Leave without pay

If you are on an authorized leave without pay, you may continue your health insurance coverage. In most cases, you will be responsible for both the employee and employer shares of the premium (full share).

Your coverage while on leave is not automatic. Before going on any leave without pay, you must arrange to continue coverage with your Health Benefits Administrator.

You may be eligible for a waiver of your NYSHIP premium while on leave without pay due to total disability (see “Waiver of Premium,” page 19, for details).

Family and Medical Leave Act (FMLA)

Under FMLA, eligible employees are entitled to a maximum of 12 weeks of unpaid leave annually for specific family and medical reasons. You will only be responsible for the employee share of the premium during the 12-week FMLA leave.

If your employment terminates following the FMLA leave period, you may be required to repay the employer contribution toward the premium.

You may have the right to apply for a waiver of your NYSHIP health insurance premium during the FMLA period (see “Waiver of Premium,” page 19, for details).

Military leave

You may be eligible to continue coverage for yourself and/or your covered dependents while you are on military leave, subject to applicable state and federal laws and executive orders. Consult your Health Benefits Administrator for information on procedures and costs.

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.

Annual obligation

While you are on military leave to meet your annual obligation as a member of the Reserves or a National Guard Unit, you pay only the employee share of the premium to continue Family coverage.

Leave for active duty

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 dependents will be eligible for coverage if you had Family coverage for at least 30 days before your activation. You may be required to pay the full cost of the premium for Family coverage.

Canceling coverage while on leave

You may cancel your health insurance coverage for the time you are on leave. Your coverage will end on the last day of the month in which your request to cancel your coverage occurred. You may enroll at a later date, usually subject to the late enrollment waiting period (see “When Coverage Begins,” page 14).

When You May Reenroll

Before you return to work

If you reinstate your coverage while on leave before you return to work, in most cases you will be subject to a late enrollment waiting period (see *Enrollment*, page 14). To request that your coverage be reinstated, contact your Health Benefits Administrator.

When you return to work

You may reenroll in NYSHIP when you return to work from a leave, provided you still meet the eligibility requirements. Contact your Health Benefits Administrator to reactivate your coverage.

Other Changes that Affect Coverage

Change in hours worked

If you experience a change in hours, your eligibility for coverage may be affected. See your Health Benefits Administrator if you experience a change in hours.

- **Reduction in hours:** If your hours are reduced and you are no longer eligible for NYSHIP coverage, your coverage will end on the last day of the month for which coverage was paid. You may be eligible for coverage through COBRA (see page 23).
- **Increase in hours:** If your hours are increased after coverage had been terminated because of a reduction in your hours, contact your Health Benefits Administrator to reenroll in NYSHIP coverage.

Termination of employment

If your employment terminates and you are not eligible to continue coverage under the terms outlined in the preceding sections, contact your Health Benefits Administrator for the date your coverage will end. When your coverage ends, you will no longer have health insurance coverage through NYSHIP unless you are eligible to retire (page 29), vest coverage (page 28), elect COBRA coverage (page 23) or elect a direct-pay contract (page 27).

Cancellation for nonpayment of premium

If you do not make your premium payments, your last day of coverage will be the last day of the month for which coverage was paid.

Consider the consequences

Canceling your coverage or letting it lapse by failing to pay the premium can result in serious consequences. You have no rights to NYSHIP health coverage if you vest or retire while your coverage is canceled. Your dependents will have no rights to coverage under COBRA or as dependent survivors if your coverage is not in effect and you resign, vest, retire or die.

Eligibility for Preferred List status

You may be eligible to continue coverage for up to one year from the time your employment is terminated if your employer offers Preferred List coverage. You may be required to pay the full cost of coverage, and additional requirements may apply. Contact your Health Benefits Administrator for information. As an enrollee with Preferred List status, the second part of this book applies to you (see pages 42-74).

If you are entitled to continue coverage under Preferred List status, you may continue coverage for up to one calendar year from the date your health insurance in active employee status ends or until you are reemployed in a benefits-eligible position by a public or private employer, whichever occurs first.

If you are temporarily employed and are eligible for health insurance, your Preferred List health insurance coverage ends. You may reinstate Preferred List coverage when your temporary job ends if the end date of your one year of Preferred List eligibility has not passed. Temporary employment does not extend your eligibility beyond one year from the date your coverage as an employee ended. To protect your health insurance coverage, you must notify the Employee Benefits Division Preferred List Unit when you begin and end temporary employment.

When your year of Preferred List coverage ends, you may be eligible to continue coverage as a retiree (page 29), vestee (page 28), temporarily under COBRA (page 23) or under a direct-pay conversion contract (page 27).

Enrollment is automatic

If the Employee Benefits Division receives notice from your agency that you have been laid off or displaced from your position and placed on a Preferred List, you will be eligible for and enrolled in Preferred List coverage (if your employer offers Preferred List coverage). The Employee Benefits Division will bill you monthly.

Waiver of Premium

You may be entitled to have your health insurance contribution waived for up to one year. You must have been totally disabled as a result of sickness or injury on a continuous basis for a minimum of three months and also meet the following additional criteria:

- You must be on authorized leave without pay, unpaid leave, covered under FMLA or covered under Preferred List provisions for health insurance. You are not eligible for a waiver if you are still receiving income through salary, leave accruals, Workers' Compensation or retirement allowance.
- You kept your coverage in effect while you were off the payroll by paying the required full cost of your health insurance premium while you were on leave without pay or covered under Preferred List provisions for health insurance.

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 of the premium.

How to apply for a waiver of premium

To apply for a waiver of premium, obtain the form *Application for Waiver of Premium* (PS-452) from your Health Benefits Administrator. Return the completed application to the address on the form.

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, vest or retire.

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

Additional waiver of premium

If you have 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 in order to qualify for an additional waiver.

If you return to work after receiving a waiver of premium and are subsequently certified as totally disabled due to the same disability, the following rules apply:

- If you return to work for less than three months, you may resume coverage under the previous waiver for the remainder of the original one-year period (including the time back at work).
- If you return to work for three or more consecutive months, 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 your employer if an additional waiver has been granted.

Waiver ends

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

- you are no longer certified as totally disabled
- you return to the payroll
- you are no longer in a status of leave without pay or on FMLA leave
- the agency that employs you no longer participates in NYSHIP
- you are no longer an employee of the agency that provided your NYSHIP benefits
- you are not covered under Preferred List health insurance provisions
- you vest your health insurance coverage rights
- you separate from service or are terminated
- you retire
- you die

Dependent Survivor Coverage

Enrolled dependents may be eligible to continue NYSHIP coverage if the enrollee predeceases them. See the following for dependent survivor eligibility rules.

To ensure that dependent survivors receive the benefits that they are entitled to, it is important to send a copy of the enrollee's death certificate to the former employee's Health Benefits Administrator as soon as possible. Notification to a retirement system does not satisfy this requirement.

Note: Survivors of COBRA enrollees are not eligible for the extended benefits period or dependent survivor coverage. Refer to the *COBRA: Continuation of Coverage* section starting on page 23 for information on coverage options.

Extended Benefits Period at No Cost

Dependents covered at the time of the enrollee's death will continue to receive coverage without charge for a period of three months beyond the last month for which the enrollee paid for NYSHIP coverage. This is referred to as the *extended benefits period*.

During the extended benefits period, enrolled Empire Plan dependents continue to use the health insurance benefit cards they already have under the enrollee's identification number. Enrolled dependents of HMO enrollees may receive a new card; contact your HMO for more information.

Eligibility for Dependent Survivor Coverage after the Extended Benefits Period Ends

After the extended benefits period ends, enrolled dependents may elect to continue NYSHIP coverage if they are eligible for dependent survivor coverage. To be eligible for dependent survivor coverage, the enrollee must have completed at least 10 years of service, and the dependent must have been covered under NYSHIP as the enrollee's dependent at the time of death. If the enrollee's death was the result of a documented work-related illness or injury, the 10-year service requirement is waived. Contact the former employee's Health Benefits Administrator for information.

The following dependents covered at the time of the enrollee's death may be eligible for dependent survivor coverage:

- a spouse who has not remarried
- a domestic partner who has not married or acquired a new domestic partner (if the former employer provides coverage for domestic partners)
- dependent children who meet the eligibility requirements (see *Dependent Eligibility*, page 7)

Only dependents covered by the enrollee at the time of death or newborn children of the enrollee born after the enrollee's death are eligible for dependent survivor coverage. Each dependent survivor is eligible to continue NYSHIP coverage in his or her own right. Eligible dependent survivors may be enrolled in Individual coverage, Family coverage or a combination thereof.

A covered dependent who is not eligible for dependent survivor coverage may be eligible to continue NYSHIP coverage under COBRA (page 23) or may be eligible to convert to a direct-pay contract (page 27).

NYSHIP coverage will end permanently for eligible dependent survivors if they:

- **do not make a timely election of dependent survivor coverage or**
- **fail to make the required payments**

They may not reenroll.

Cost of Dependent Survivor Coverage

Your dependent survivors may be required to pay any amount up to the full premium. Check with the Health Benefits Administrator of the former employer for contribution rates.

Benefit cards

After the extended benefits period ends, the primary dependent survivor becomes the enrollee. In most cases, this will be the spouse or domestic partner.

- **Empire Plan enrollees:** Dependent survivors will be mailed benefit information and a new Empire Plan benefit card with the survivor's name.
- **HMO enrollees:** Check with the HMO regarding benefits and new cards.

Dependent Eligible for NYSHIP as a Result of Employment

A dependent employed by or previously employed by New York State, a Participating Employer or a Participating Agency may be eligible to reinstate coverage as an enrollee in NYSHIP. Coverage as a current or former employee may be less expensive than coverage as a dependent survivor.

Survivors who were previously employed by a Participating Agency should write to the Participating Agency to ask about reenrollment. Survivors who were previously employed by New York State or a Participating Employer should write to the Employee Benefits Division with details of relevant prior employment to determine if they are eligible to reinstate coverage as enrollees.

Loss of Eligibility for Dependent Survivor Coverage

If a dependent loses eligibility for dependent survivor coverage, the dependent may be eligible to continue coverage in NYSHIP under COBRA (see page 23) or to convert to a direct-pay contract (see page 27).

Eligibility for dependent survivor coverage ends permanently if a:

- spouse remarries
- domestic partner acquires a new domestic partner or marries
- dependent child no longer meets the eligibility requirements (see page 8)
- dependent survivor fails to make the required payments

If NYSHIP coverage as a dependent survivor is terminated for any reason, eligibility ends and the dependent is not eligible to reenroll.

If a surviving spouse or domestic partner loses eligibility or dies, eligible dependent children may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents.

End Dates for Coverage

If you or your dependent is no longer eligible for NYSHIP coverage, in certain cases, coverage may be continued under COBRA (see *COBRA: Continuation of Coverage*, page 23).

You, the Enrollee

Loss of eligibility

NYSHIP coverage will end on the last day of the month if your employment ends on or before the 15th day of that month. Coverage ends on the last day of the following month if your employment ends after the 15th day of the month. If your eligibility ends, contact your Health Benefits Administrator.

Suspending coverage

If you choose to suspend coverage while on a leave of absence, your coverage will end on the last day of the last month for which you paid the NYSHIP premium.

Consequences

If you die while your coverage is canceled or suspended, your dependents will have no right to continue coverage as dependent survivors.

If you cancel your enrollment while you are in vestee status, you will not be eligible to reenroll in NYSHIP as a vestee unless you have maintained continuous NYSHIP coverage elsewhere.

Dependent Loss of Eligibility

Contact your Health Benefits Administrator as soon as your dependent no longer qualifies for coverage.

If you choose to change from Family to Individual coverage when your dependents are still eligible, coverage for your dependents will end on the last day of the month in which you request this change.

Children

Coverage for most dependent children ends on the last day of the month in which the child reaches age 26 (or adjusted age 26, for dependent children with qualifying military service). In certain cases, coverage ends on the date the child loses eligibility for a reason other than age (refer to “Your disabled

child” on page 9 and “Your ‘other’ child” on page 8 for special eligibility requirements). Your child, up to age 30, may be eligible to enroll in NYSHIP coverage under the Young Adult Option (see page 40).

Children who lose eligibility and then reestablish dependent eligibility may reenroll. Unmarried, disabled dependent children who lost eligibility can be covered under NYSHIP if the same disability that qualified them as disabled dependents while they were enrolled in NYSHIP again renders them incapable of self-support. Appropriate documentation will be required.

Former spouse

Coverage ends for your former spouse on the date that the judgment of divorce is entered (filed) with the clerk of the court.

Former domestic partner

Coverage ends for your former domestic partner on the effective date of the dissolution of the domestic partnership or when the domestic partnership requirements are no longer met (submit the completed form *Termination of Domestic Partnership* [PS-425.4] to your Health Benefits Administrator). Be sure to provide a copy of the form to your former domestic partner.

COBRA: Continuation of Coverage

Federal and State Laws

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows enrollees and their families to continue their health coverage in certain instances when coverage would otherwise end. In addition to the federal COBRA law, the New York State continuation coverage law, or “mini-COBRA,” extends the continuation period. Together, the federal COBRA law and NYS “mini-COBRA” provide 36 months of continuation coverage. Both laws are collectively referred to as “COBRA” throughout this book.

COBRA enrollees pay the full cost of coverage, and the employer may also charge a two percent administrative fee. There is no employer contribution to the cost of coverage. See “Costs under COBRA” later in this section.

Benefits under COBRA

COBRA benefits are the same benefits offered to employees and dependents enrolled in NYSHIP. You must apply for COBRA within 60 days from the date of loss of eligibility (see “Deadlines Apply,” page 25). Documentation of the COBRA-qualifying event may be required.

Eligibility

Enrollee

If you are a NYSHIP enrollee who is no longer covered through active employment, you have the right to COBRA coverage if your:

- eligibility for NYSHIP is lost as a result of a reduction in hours of employment or termination of employment
- NYSHIP coverage is canceled while on leave under the Family and Medical Leave Act (FMLA) and you do not return to work
- employer provided you coverage under Preferred List provisions, and that coverage has been exhausted. **Note:** You may be eligible to continue coverage as a retiree (page 29) or vestee (page 28).

Dependents who are qualified beneficiaries

Dependents who are qualified beneficiaries have an independent right to up to 36 months of COBRA coverage (from the date coverage is lost due to your initial COBRA-qualifying event) and may elect Individual coverage. To be considered a qualified beneficiary, a dependent must:

- have been covered at the time of the enrollee's initial COBRA-qualifying event or
- be a newborn or newly adopted child added to coverage within 30 days of birth or placement for adoption.

Spouse/domestic partner

The covered spouse or domestic partner of a NYSHIP enrollee has the right to COBRA coverage as a qualified beneficiary if coverage under NYSHIP is lost as a result of:

- divorce
- termination of domestic partnership
- termination or reduction in hours of enrollee's employment
- death of the enrollee
- the COBRA enrollee's eligibility for Medicare*

Dependent children

The covered dependent child of a NYSHIP enrollee has the right to COBRA as a qualified beneficiary if coverage under NYSHIP is lost as the result of:

- the child's loss of eligibility as a dependent under NYSHIP (e.g., due to age)
- parents' divorce or termination of domestic partnership
- termination or reduction in hours of enrollee's employment
- death of the enrollee
- the COBRA enrollee's eligibility for Medicare*

A COBRA enrollee's newborn child or a child placed for adoption with a COBRA enrollee is considered a qualified beneficiary if coverage for the child is requested within 30 days (see "Covering newborns," page 12, in *Coverage: Individual or Family* for enrollment rules).

**In no case will any period of continuation coverage last more than 36 months from the initial COBRA-qualifying event.*

Dependents who are not qualified beneficiaries

An eligible dependent may be added to COBRA coverage at any time in accordance with NYSHIP rules (see *Dependent Eligibility*, page 7, and *Coverage: Individual or Family*, page 11). However, a dependent added during a period of COBRA continuation coverage is not considered a qualified beneficiary (with the exception of a newborn or newly adopted child added within 30 days). Dependents who are not qualified beneficiaries may only maintain coverage for the remainder of the enrollee's eligibility for COBRA continuation coverage.

Medicare and COBRA

When NYSHIP requires you or your covered dependent to enroll in Medicare, your NYSHIP COBRA coverage will be affected differently depending on which coverage you were enrolled in first. Read the section, "When You are Required to Have Medicare Parts A and B in Effect" in *Medicare and NYSHIP*, page 37, to learn when NYSHIP requires Medicare coverage to be in effect.

- If you are already covered under COBRA when you enroll in Medicare, your NYSHIP COBRA coverage ends at the point when Medicare enrollment becomes effective. However, your eligible dependents who are considered qualified beneficiaries may continue their NYSHIP COBRA coverage for the remainder of the 36 months of COBRA continuation coverage (see “Continuation of Coverage Period” on page 26 of this section).
- If you do not enroll in Medicare when first eligible for Medicare-primary coverage, your NYSHIP coverage will be canceled or substantially reduced.
- If you are already covered under Medicare when you elect COBRA coverage, your Medicare coverage will pay first. When enrolled in COBRA, Medicare is your primary coverage.

Choice of Option

An enrollee or dependent who continues coverage under COBRA will continue to be covered under the same option. COBRA enrollees may change to a different option during the annual Option Transfer Period (see *Your Options Under NYSHIP*, page 4) or when moving under the circumstances described in “Qualifying Life Events: Changing Your NYSHIP Option outside the Option Transfer Period” in *Your Options Under NYSHIP*, page 5. Dependents of a COBRA enrollee who are qualified beneficiaries may also change to Individual coverage during the annual Option Transfer Period.

Deadlines Apply

Once your employer is notified of a COBRA-qualifying event, an application for COBRA coverage will be mailed to the address on record. Be sure to read the application carefully. To continue coverage, the application must be completed and returned by the response date provided on the notice.

60-day deadline to elect COBRA

You must elect continuation coverage within **60 days** from the date of the COBRA-qualifying event or 60 days from the date you are notified of your eligibility for continuation coverage, whichever is later.

Notification of dependent’s loss of eligibility

To be eligible for COBRA coverage, the enrollee or covered dependent must notify the Health Benefits Administrator within 60 days from the date a covered dependent is no longer eligible for NYSHIP coverage, for reasons such as:

- a divorce
- termination of a domestic partnership
- a child’s loss of eligibility as a dependent under NYSHIP (see “Dependent Loss of Eligibility” in *End Dates for Coverage*, page 22).

Other people acting on your behalf may provide written notice of a COBRA-qualifying event to your Health Benefits Administrator.

If your Health Benefits Administrator does not receive notice in writing within that 60-day period, the dependent will not be entitled to choose continuation coverage.

Costs under COBRA

COBRA enrollees may pay 100 percent of the premium for continuation coverage, and may be required to pay an additional two percent administrative fee. The Employee Benefits Division will bill you for the COBRA premiums.

45-day grace period to submit initial payment

COBRA enrollees will have an initial grace period of 45 days to pay the first premium starting with the date continuation coverage is elected. Since the 45-day grace period applies to all premiums due for periods of coverage prior to the date of the election, several months' premiums could be due and outstanding. Once you elect COBRA coverage, you will receive a bill for coverage. Ask the Employee Benefits Division whether you will receive subsequent payment reminders.

30-day grace period

After the initial 45-day grace period, enrollees will have a 30-day grace period from the premium due date to pay subsequent premiums.

Payment is considered made on the date of the payment's postmark.

Continuation of Coverage Period

You and your eligible dependents may have the opportunity to continue coverage under COBRA for up to 36 months.

If you lose COBRA eligibility prior to the end of the 36-month continuation coverage period, the duration of your dependents' coverage is as follows.

- **Dependents who are qualified beneficiaries:** COBRA continuation coverage may continue for the remainder of the 36 months.
- **Dependents who are not qualified beneficiaries:** COBRA continuation coverage will end when your coverage ends.

Survivors of COBRA enrollees

If you die while you are a COBRA enrollee in NYSHIP, your enrolled dependents who are qualified beneficiaries will be eligible to continue COBRA coverage for up to 36 months from the original date of COBRA coverage or may be eligible to convert to a direct-pay contract (see page 27).

When You No Longer Qualify for COBRA Coverage

Continuation coverage will end for the following reasons:

- The premium for your continuation coverage is not paid on time.
- The continuation period of up to 36 months ends.
- The enrollee or enrolled dependent enrolls in Medicare.
- Your employer no longer participates in NYSHIP.

To Cancel COBRA

Notify the Employee Benefits Division if you want to cancel your COBRA coverage (see "Model Letter for Contacting the Employee Benefits Division" on page 89 of the Appendix).

Conversion Rights after COBRA Coverage Ends

At the end of your COBRA coverage period (if you were an Empire Plan enrollee), you may be eligible to convert to a direct-pay conversion contract with the Empire Plan's Medical/Surgical Program administrator (see *Contact Information*, page 90).

If you choose COBRA coverage, you must exhaust those benefits before converting to a direct-pay 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 a direct-pay policy.

If you were enrolled in a NYSHIP HMO, contact that HMO for more information.

Other Coverage Options

There may be other coverage options available to you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan).

Contact Information

If you have any questions about COBRA, but are not currently enrolled, please contact your Health Benefits Administrator. If you are enrolled in COBRA, contact the Employee Benefits Division.

Direct-Pay Conversion Contracts

After NYSHIP coverage ends, or after eligibility for continuation coverage under COBRA ends, certain enrollees and their covered dependents are eligible for coverage through a direct-pay conversion contract. The benefits and the premium for direct-pay conversion contracts will be different from what you had under NYSHIP.

Eligibility

Empire Plan enrollees and/or covered dependents who lose eligibility for coverage for any of the following reasons may convert to a direct-pay contract:

- loss of eligibility for coverage as a dependent
- death of the enrollee (when the dependent is not eligible to continue coverage as a dependent, as explained in *Dependent Survivor Coverage*, page 20)
- eligibility for COBRA continuation coverage ends, except when the loss of eligibility is the result of becoming Medicare-eligible due to age

A direct-pay conversion contract is not available to enrollees and/or covered dependents who:

- voluntarily cancel their coverage
- had coverage canceled for failure to pay the NYSHIP premium
- have existing coverage that would duplicate the conversion coverage
- are eligible for Medicare because of age

If you were enrolled in a NYSHIP HMO, contact that HMO for more information.

Deadlines Apply

You should receive written notice of any available conversion rights within 15 days after your coverage ends.

Your application for a direct-pay conversion policy and the first premium must be submitted within:

- 45 days from the date your coverage ends, if you receive the notice within 15 days after your coverage ends
- 45 days from the date you receive the notice, if you receive written notice more than 15 days, but less than 90 days, after your coverage ends
- 90 days from the date your coverage ends, if no notice of the right to convert is given

No Notice for Certain Dependents

Written notice of conversion privileges will not be sent to dependents who lose their status as eligible dependents. For a direct-pay conversion contract, these dependents must apply within 45 days of the date coverage terminated.

How to Request Direct-Pay Conversion Contracts

To request a direct-pay conversion policy, write to the Empire Plan Medical/Surgical Program administrator (see *Contact Information*, page 90).

If you were enrolled in a NYSHIP HMO, contact that HMO for more information.

Vestee Coverage

If your employment with a Participating Employer ends before you are eligible for coverage as a retiree, you are a member of a class or category of employee for which your employing agency provides coverage in retirement and you meet the eligibility requirements below, you may protect your future eligibility for retiree coverage. To do so, you must maintain continuous NYSHIP coverage until you are eligible to collect a pension.

You may continue coverage as:

- an enrollee in vestee coverage with your former employer
- a dependent of a NYSHIP enrollee
- an enrollee in another agency that offers NYSHIP coverage

Continuing NYSHIP Coverage as a Vestee

Eligibility

If your employment with a Participating Employer ends before you are eligible to collect a pension and you vest your retirement allowance, you are eligible to continue your NYSHIP coverage as a vestee if you:

- are a member of a class or category of employee for which your employer provides coverage in retirement;
- have vested as a member of a retirement system administered by the State or one of its political subdivisions (such as a municipality);
- have met your employer's minimum service requirement (see "Eligibility Requirements for NYSHIP Coverage" on page 30 in *Eligibility to Continue Coverage as a Retiree*) but are not yet eligible to collect a pension at the time employment is terminated; and
- are within five years of retirement eligibility (if your agency has adopted this requirement; if your agency has not adopted this requirement, you only need to meet the first three eligibility requirements on this list).

If you are a member of the State University of New York Optional Retirement Program with a vendor such as TIAA/CREF, you will maintain vestee coverage until you meet the age requirement of the Employees' Retirement System retirement tier in effect at the time you last entered service.

Note: Employees who are members of certain retirement systems, such as the New York State Local Police & Fire Retirement System, are eligible to retire after a specific number of years of service, regardless of age.

Enrollment

For information on how to continue coverage as a vestee if your employment with a Participating Employer ends, contact your Health Benefits Administrator. Failure to apply in a timely manner can result in a lapse of coverage resulting in a loss of eligibility to continue coverage.

Cost

If you choose to continue your coverage as an enrollee in vestee coverage, there is no employer contribution to the cost of coverage; you are responsible for paying the full cost of your NYSHIP coverage until you become eligible for coverage as a retiree. Contact your Health Benefits Administrator regarding payment and billing information.

If your coverage is canceled for nonpayment of premium, you may lose your right to continue coverage as a retiree.

Sick leave credit does not apply

Sick leave credits cannot be applied toward health insurance premium costs either while you are in vested status or after retiring from vested status.

Continuing Your NYSHIP Coverage as a Dependent

If you maintain continuous coverage in NYSHIP as a dependent, you may reestablish enrollment in vestee coverage or retiree coverage (when eligible) as long as you have not allowed your coverage as a dependent to lapse.

Contact your Health Benefits Administrator to begin coverage in your own name. Act promptly if a pending divorce or other change means you will be losing coverage as a dependent. It is your responsibility to ensure that your coverage is continuous.

Eligibility to Continue Coverage as a Retiree

Your employer may permit enrollees who meet certain eligibility requirements to continue NYSHIP coverage in retirement; these requirements vary from employer to employer. **Contact your Health Benefits Administrator for specific details about how this applies to you.** The information in this section may be used as a general guideline.

Note: If you receive prescription drug coverage through a union Employee Benefit Fund, you may continue to receive this coverage after you retire. Contact the union Employee Benefit Fund for information on how your prescription drug coverage may be affected by retirement.

Employers that participate in NYSHIP are required to comply with the following rules:

- **Employers that elected to participate in NYSHIP before March 1, 1972:** If your employer elected to participate in NYSHIP before March 1, 1972, retiree coverage must be offered to individuals who were hired prior to April 1, 1977, and who meet eligibility requirements for retiree coverage.
- **Employers that elected to participate in NYSHIP on or after March 1, 1972:** If your employer elected to participate in NYSHIP on or after March 1, 1972, you must be a member of a class or category of employee for which your employer has elected—administratively or through collective bargaining—to provide coverage in retirement and you must meet the eligibility requirements for retiree coverage.
- **Employees most recently hired by their employer on or after April 1, 1977:** Employers may elect—administratively or through collective bargaining—to exclude employees from eligibility to continue coverage in retirement if the employee's most recent date of hire with the agency is on or after April 1, 1977. This exclusion from eligibility may apply to all employees, or to one or more classes or categories of employees.

Dental and vision coverage

If you were covered through the NYS Dental Program and/or Vision Program as an employee, that coverage ends when you retire. You will receive a COBRA application from the Employee Benefits Division and may be eligible to continue coverage under COBRA by paying the full cost, plus a two percent administrative fee. You may also be eligible to purchase a direct-pay contract through the NYS Dental Program at the time you retire or when your COBRA coverage ends. Refer to your dental and vision plan materials for additional information.

If you had coverage through a union Employee Benefit Fund, contact the union Employee Benefit Fund for information about continuing dental and/or vision coverage as a retiree.

Eligibility Requirements for NYSHIP Coverage

The requirements to receive a pension are different from NYSHIP's requirements to continue health coverage as a retiree.

You will not be eligible to continue NYSHIP health coverage as a retiree if you do not meet the requirements outlined in this section and submit all required materials to your Health Benefits Administrator. Read this eligibility information carefully.

Note: If your Participating Employer offers a health benefits opt out or coverage outside of NYSHIP, ask your HBA whether enrollment in these alternative options satisfies the requirement to enroll in NYSHIP as a retiree.

To continue NYSHIP coverage as a retiree, you must meet the following eligibility requirements:

1. Be in a class or category of employee that is eligible for coverage in retirement.

Your employer may or may not offer you NYSHIP coverage in retirement. Contact your Health Benefits Administrator to find out if you are in a class or category of employee eligible to continue NYSHIP coverage in retirement.

2. Complete your employer's minimum service requirement.

You must satisfy the service requirement of the employer from which you are retiring. NYSHIP requires at least five years of benefits-eligible service. The service does not need to be continuous.

If you were most recently hired with your employer on or after April 1, 1975, your agency may elect—administratively or through collective bargaining—to establish a service requirement greater than five years. This requirement may apply to all employees, or to one or more classes or categories of employees.

Unpaid board members: Check with your Health Benefits Administrator to see if you are eligible to continue NYSHIP coverage in retirement.

Credit for service with other public employers

Your employer may elect—administratively or through collective bargaining—to allow certain classes or categories of employees to count public service with any public employer toward their minimum service requirement. If you are in a class or category of employee to which your employer has extended this provision, you must have a minimum of one year of qualifying service with the employer from which you are retiring to be eligible to continue NYSHIP coverage in retirement from that employer.

If you believe you have other qualifying service, check with your Health Benefits Administrator to see whether that service counts toward meeting the minimum service requirement.

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

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 Retirement System) or any of New York State's political subdivisions.

If you are not a member of one of these retirement systems, or if you are enrolled in the State University of New York (SUNY) Optional Retirement Program (ORP) with a vendor such as Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA/CREF), you must meet the age requirement of the NYS and Local Employees' Retirement System tier in effect at the time you last entered service.

Note: If you retire and delay collecting your pension or delay receiving disbursements from the SUNY ORP, you may continue your NYSHIP coverage under retiree provisions, provided you meet the eligibility requirements listed on the preceding page. This is referred to as “constructive retirement.”

4. Be enrolled in a health benefit option through an employer that participates in NYSHIP.

You must be enrolled in NYSHIP as an active enrollee or a dependent at the time of your retirement. Enrollment in NYSHIP may be through The Empire Plan or a NYSHIP HMO.

The following examples satisfy the requirement to be enrolled in a NYSHIP employer-sponsored option at the time of retirement:

Example 1: Joe is enrolled in NYSHIP coverage offered by his employer, which is a Participating Employer.

Example 2: Paul is covered as a dependent of his wife, Penelope. Both Paul and Penelope work for employers that offer NYSHIP coverage.

Example 3: John is enrolled in an HMO option offered by his employer. His employer also offers NYSHIP coverage.

Disability Retirement

Whether your retirement is considered a service retirement or a disability retirement, you will have the same benefits and will be subject to the same policies. However, the requirements you must meet to be eligible for NYSHIP coverage in retirement may be different.

If you are applying for a disability retirement, be sure to contact your Health Benefits Administrator to discuss your options.

- **Ordinary disability retirement:** For an ordinary (not work-related) disability retirement granted by an approved retirement system, you must meet all requirements outlined in the preceding section, “Eligibility Requirements for NYSHIP Coverage,” page 30.
- **Work-related (accidental) disability retirement:** For a disability retirement resulting from a work-related illness or injury granted by an approved retirement system, your employer’s minimum service requirement is waived.

Maintain coverage while your disability retirement is being decided

To ensure continued eligibility for NYSHIP coverage after you retire, maintain NYSHIP coverage while you wait for the decision on your disability retirement.

If your disability retirement is not approved, and you did not maintain NYSHIP coverage (while on leave or in vestee or COBRA status), coverage for you and your dependents will end. **You will not be eligible to reenroll in NYSHIP.**

Disability retirement award

To request retiree coverage after you receive a disability retirement award, contact your Health Benefits Administrator as soon as you receive the decision on your disability retirement. Provide a copy of the award letter from the retirement system that includes your disability retirement effective date (for an example of this letter, refer to page 88 of the *Appendix*).

The date your retiree coverage begins will depend on the type of disability retirement you receive.

- If you receive an ordinary disability retirement, your retiree coverage will begin after you complete a three-month late enrollment waiting period, starting from the date you request to be reinstated.

- If you receive a work-related disability retirement, you may choose to have your retiree coverage begin either:
 - on your retirement date or
 - on the first day of the month following the date of your request

If your coverage was canceled while you were waiting for the decision on your disability retirement, contact your Health Benefits Administrator. Your agency may permit you to reinstate coverage if you act promptly and pay any retroactive premiums you missed while your coverage was canceled, up to the effective date of your disability retirement.

What You Pay

Retirees pay a portion of their NYSHIP health insurance premium. The amount you pay to maintain your health coverage in retirement depends on a number of factors, including your:

- contribution rate
- health insurance option
- type of coverage (Individual coverage or Family coverage)
- sick leave credit, if any

The Employee Benefits Division will notify you of the monthly amount you must pay.

How You Pay

When you retire, you will pay your share of the health insurance premium through deductions from your monthly retirement check or by making monthly payments directly to the Employee Benefits Division, or, in some cases, directly to your former employer.

If you are eligible and elect to have your share of the monthly premium deducted from your pension check, 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 deductions. Once your eligibility for retiree benefits has been confirmed by the Employee Benefits Division, you will be billed directly each month for your share of the premium until deductions from your pension check begin. Your coverage will remain in effect until your eligibility for retiree benefits has been confirmed, but during that time you may not receive communication from the Employee Benefits Division.

Sick Leave Credit

Participating Employers may or may not offer sick leave credit or may choose to offer sick leave credit only to certain classes or types of employees. If you have any questions about your eligibility for sick leave credit, contact your Health Benefits Administrator.

If you retire directly from the payroll or retire while covered under Preferred List provisions for health insurance and earn sick leave, you may be entitled to use the value of your unused sick leave to offset the cost of NYSHIP coverage in retirement. This will not affect the value of your sick leave for pension purposes.

When you retire, your agency provides the Employee Benefits Division with the information necessary to calculate your sick leave credit, if any. The “Dear Retiree” letter (see page 82 for an example) from the Employee Benefits Division will report this monthly sick leave credit. If you believe this credit is incorrect, contact your Health Benefits Administrator. This letter will also include the monthly cost of your coverage in retirement for the option you are currently enrolled in (at the current rate for that option). **Keep this letter for future reference.**

To calculate the value of your sick leave credit, visit www.cs.ny.gov/employee-benefits and choose your group and plan. From the NYSHIP Online homepage, select Planning to Retire, then Sick Leave Credit Calculator. Or, ask your Health Benefits Administrator for a *Worksheet for Estimating Sick Leave Credit*.

This credit cannot be applied to a COBRA premium and cannot be combined with your spouse’s or domestic partner’s sick leave credit.

Lifetime monthly credit

When you retire, if you are eligible for sick leave credit, your unused sick leave is converted into a dollar amount by dividing the dollar value of your sick leave by your actuarial life expectancy in months. The result is a monthly credit that is applied to your NYSHIP premium.

Before you retire, submit the form *Sick Leave Credit Election* (PS-405) to your Health Benefits Administrator; you must choose whether you want to use 100 percent of your sick leave credit or the Dual Annuitant Sick Leave Credit Option (if your employer offers the Dual Annuitant Sick Leave Credit Option). You cannot change your election after you retire (read more on the Dual Annuitant Sick Leave Credit Option in the following section).

If you do not complete this form before your retirement, 100 percent of your sick leave credit will be applied to your premium. If you predecease your dependents, they will not have any sick leave credit to offset the cost of their NYSHIP premium.

The amount of your monthly credit will remain the same throughout your lifetime. However, the balance you pay may change when premium rates change.

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

To estimate the value of your sick leave credit, use the online Sick Leave Credit Calculator. Go to www.cs.ny.gov/employee-benefits and choose your group and plan. From the NYSHIP Online homepage, click on Planning to Retire. Scroll down and select the Sick Leave Credit Calculator link.

When sick leave credit ends

Your monthly sick leave credit ends when you die, unless you chose the Dual Annuitant Sick Leave Credit Option.

The Dual Annuitant Sick Leave Credit Option

Prior to your retirement, if you are eligible for sick leave credit and if your employer offers the Dual Annuitant Sick Leave Credit Option, you may elect the Dual Annuitant Sick Leave Credit Option. This election will allow your dependent survivors to continue to use your monthly sick leave credit toward their NYSHIP premium after you die. To enroll, you must choose this option before your last day on the payroll. Confirm that your dependent will qualify for coverage as a dependent survivor before electing this option. (See *Dependent Survivor Coverage* on page 20.)

If you choose the Dual Annuitant Sick Leave Credit Option, you will use 70 percent of your sick leave credit for your premium for as long as you live. This 70 percent monthly credit will continue to be applied to the NYSHIP premium for your eligible dependents who outlive you. If your dependents die before you, you will retain the 70 percent sick leave credit. (Regardless of whether or not you choose the Dual Annuitant Sick Leave Credit Option, your surviving dependents will be eligible to continue coverage after your death if they meet the NYSHIP eligibility requirements outlined in *Dependent Survivor Coverage* on page 20.)

You must elect the Dual Annuitant Sick Leave Credit Option prior to retirement. Contact your Health Benefits Administrator to complete the form *Sick Leave Credit Election* (PS-405). You may choose this option whether you have Individual or Family coverage.

Your election cannot be changed on or after your retirement date.

Spouses who are both eligible for sick leave credit

Prior to retirement, both you and your spouse need to document sick leave credit and choose an option.

If you and your spouse are both eligible for NYSHIP coverage in retirement (and are both eligible for sick leave credit), you must each do the following:

- Submit the form *Sick Leave Credit Election (PS-405)* and choose either the single annuitant or dual annuitant option (even if one person is covered as a dependent).
- Ask your Health Benefits Administrator to complete the form *State Service Sick Leave Credit Preservation (PS-410)* prior to retirement. This form provides evidence of your service and sick leave credit.

Each of you maintains the right to your sick leave credits and can choose the dual annuitant option whether you are enrolled in one Family coverage or in two Individual coverages. If you and your spouse have chosen a single Family coverage, only the enrollee's sick leave credit is applied to the cost of health coverage. You and your spouse or domestic partner cannot combine your sick leave credit amounts.

Reactivating Individual enrollment

Monthly sick leave credit will be established for a dependent spouse when he or she reactivates his or her own coverage, provided the value of unused sick leave can be documented. When a dependent spouse applies for coverage in his or her own name, the completed form, *State Service Sick Leave Credit Preservation (PS-410)*, or agency verification with a letter requesting coverage must be sent to the Employee Benefits Division. For information on reactivating enrollment in NYSHIP, contact the Employee Benefits Division.

Deferred Health Insurance Coverage

When you retire, you may delay your enrollment in retiree health insurance coverage and the use of your sick leave credit indefinitely (if eligible for sick leave credit) if you have other employer-sponsored group coverage. To defer your coverage, you must contact your Health Benefits Administrator and fill out the form *Request to Defer Retiree Health Benefits (PS-406.2)*.

If you choose to defer, you must do it before your last day on the payroll.

If you defer the start of your retiree coverage, your monthly sick leave credit may be higher because when it is calculated, it will be based on your age at the time you enroll. You may start your deferred retiree health insurance coverage at any time without a waiting period.

To document the value of your sick leave credit, ask your Health Benefits Administrator to complete the form *State Service Sick Leave Credit Preservation (PS-410)* at retirement. This form provides evidence of State service and sick leave credit.

If you had Family coverage at the time you deferred and you predecease your dependents, they may be eligible to enroll as dependent survivors. They must write to the Employee Benefits Division to request reenrollment in NYSHIP within 90 days of the date of your death. Eligibility requirements for your spouse and eligible dependents to reenroll in NYSHIP are the same as if you had continued your coverage in retirement.

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

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

If you are covered as a dependent of another NYSHIP enrollee at the time you retire and you elect to defer the start of your own retiree coverage, complete the form *State Service Sick Leave Credit Preservation (PS-410)*.

Reenrolling as a Retiree

Under most circumstances, you will be subject to a waiting period before your coverage becomes effective again. Any sick leave credits will be maintained on your record and will be applied to your monthly premium once you reactivate enrollment.

Pre-Retirement Checklist

Contact your Health Benefits Administrator

- Ask your Health Benefits Administrator if your class or category of employment is eligible to continue NYSHIP coverage in retirement. If the answer is yes, be especially sure to discuss the minimum service requirements and carefully read the retirement information in this book.
- Make sure you meet the minimum service requirements for continuing benefits in retirement, and, that at the time you retire, you are enrolled in NYSHIP or other coverage offered by your employer. For health insurance, be especially sure to check any part-time service or service with another public employer that may count as qualifying service (if needed). Talk with your Health Benefits Administrator if you have questions.
- If you are eligible to continue NYSHIP coverage in retirement, ask your Health Benefits Administrator to verify that the information on your enrollment record (such as dates of birth, spelling of names and addresses) is accurate and up to date.
- Ask your Health Benefits Administrator if you can apply the value of your unused sick leave credit toward the cost of coverage in retirement, and, if eligible, what forms you need to complete.

Contact your Social Security Administration Office

- You must enroll in Medicare Parts A and B when first eligible for primary Medicare benefits. You will be reimbursed for the Medicare Part B premium you pay.
- If you or a dependent is already age 65 or older, call your Social Security Administration office three months before you retire to enroll in Medicare Parts A and B. To avoid a drastic reduction in benefits, you must have Medicare Parts A and B in effect when you retire. (Medicare becomes primary to NYSHIP on the first day of the month following your last day of coverage as an active employee.) When you contact Social Security, ask for a “special enrollment period” due to your change in employment status. It is your responsibility to ensure Medicare coverage is in effect at the time your active coverage ends.
- After you retire, when you or a dependent reaches age 65 and is newly eligible for Medicare, NYSHIP requires you to have Medicare Parts A and B in effect on the first day of the month you reach age 65, or the first day of the previous month if your birthday falls on the first day of the month. Plan to sign up three months before turning 65.
- After you retire, if you or your dependent is eligible for Medicare for a reason other than age (i.e., disability, end-stage renal disease, ALS), Medicare Parts A and B provide coverage that is primary to NYSHIP (see *Medicare and NYSHIP*, page 36).

If you are moving when you retire

- Before you retire, notify your Health Benefits Administrator of any change to your address and phone number.
- After you retire, to report address changes or enrollment changes, contact the Employee Benefits Division.

Medicare and NYSHIP

NYSHIP requires enrollees and covered dependents to enroll in Medicare Parts A and B when Medicare is primary to NYSHIP. You must follow NYSHIP rules to ensure that your coverage is not reduced or canceled. Do not depend on Medicare, your provider, another employer or your health plan for information about NYSHIP, since they may not be familiar with NYSHIP's rules. A change in Medicare's rules could affect NYSHIP's requirements.

COBRA enrollees: There are special rules for COBRA enrollees. Read "Medicare and COBRA" in *COBRA: Continuation of Coverage* on page 24 to determine if information in this section will apply to you.

Medicare: A Federal Program

This section provides a brief overview of Medicare. Check www.medicare.gov for complete and current information about Medicare.

Medicare is the federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people age 65 and older, and for those under age 65 with certain disabilities.

If you have questions about Medicare eligibility, enrollment or cost, contact Social Security at 1-800-772-1213, 24 hours a day, seven days a week. TTY users should call 1-800-325-0778. Or, check the web site, www.ssa.gov.

For questions about Medicare benefits, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare's web site, www.medicare.gov, also has information.

Medicare Part A* covers inpatient care in a hospital or skilled nursing facility, hospice care and home health care.

Medicare Part B* covers doctors' services, outpatient hospital services, durable medical equipment and some other services and supplies not covered by Part A and certain prescription drugs in specific situations.

**Medicare Parts A and B are referred to as "original Medicare."*

Medicare Advantage plans, formerly referred to as Medicare Part C, have a contract with CMS to provide Medicare Parts A and B, and, often, Medicare Part D prescription drug coverage, as part of a plan that provides comprehensive health coverage.

Medicare Part D is the Medicare prescription drug benefit. Medicare Part D plans can either be a part of a comprehensive plan that provides hospital/medical coverage or a standalone plan that provides only prescription drug benefits.

Combination of Medicare and NYSHIP Protects You

When you become eligible for Medicare-primary coverage as an employee or retiree enrolled in NYSHIP coverage, or when your enrolled dependent becomes eligible for Medicare that is primary to NYSHIP, the combination of health benefits under Medicare and NYSHIP provides the most complete coverage. To maximize your overall level of benefits, it is important to understand:

- NYSHIP's requirements for enrollment in Medicare Parts A and B
- how Medicare and NYSHIP work together
- how enrolling for other Medicare coverage may affect your NYSHIP coverage

NYSHIP requires you to enroll in Medicare Parts A and B when first eligible for Medicare coverage that is primary to NYSHIP. **Primary means Medicare pays health insurance claims first, before NYSHIP.** NYSHIP also requires your dependents to be enrolled in Medicare Parts A and B when they are first eligible for primary Medicare coverage.

When Medicare Eligibility Begins

You are eligible for Medicare:

- at age 65,
- regardless of age, after receiving Social Security Disability Insurance (SSDI) benefits for 24 months,
- regardless of age, after completing Medicare's waiting period of up to three months due to end-stage renal disease (ESRD) or
- when receiving SSDI benefits due to amyotrophic lateral sclerosis (ALS).

When NYSHIP is Primary

If you or a dependent becomes eligible for Medicare while you are an active employee (including a period of time when you are on a leave of absence but still maintain an employer-employee relationship), in most cases, NYSHIP will be the primary coverage for you and your covered dependents, regardless of age or disability.

While NYSHIP is primary, you or your dependent 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.
- delay enrollment in Medicare Part B until Medicare becomes primary. Check with the Social Security Administration regarding enrollment and possible late enrollment penalties.

When Medicare Becomes Primary to NYSHIP

While you are actively working, in most cases, NYSHIP is primary to Medicare. There are **two exceptions to this primacy rule**:

- Domestic partners (if domestic partner coverage is offered by your employer): Regardless of the enrollee's employment status, Medicare is primary for a domestic partner who is eligible for Medicare due to age (65 or older). A domestic partner who is eligible for Medicare due to disability and is under age 65 will receive primary coverage through NYSHIP while the enrollee is an active employee of a Participating Employer. Medicare becomes primary to NYSHIP once the enrollee retires or otherwise separates from service with a NYSHIP Participating Employer.
- End-stage renal disease: If you or your dependent is eligible for Medicare due to end-stage renal disease, contact Medicare at the time of diagnosis. Medicare becomes primary to NYSHIP when Medicare's 30-month coordination period is completed.

When you no longer have NYSHIP coverage as the result of active employment (for example, when you are covered as a retiree, vestee, Preferred List enrollee or dependent survivor, or you are covered as the dependent of one of these enrollees) and become eligible for Medicare, Medicare will be primary.

When You are Required to Have Medicare Parts A and B in Effect

The rules in this section apply if you live in one of the 50 United States or Puerto Rico, Guam, the U.S. Virgin Islands, Northern Marianas or American Samoa. If you reside outside the United States or its territories, refer to "Expenses Incurred Outside the United States" in the second part of this book on page 65.

The responsibility is yours: To avoid a reduction in the combined overall benefits provided under NYSHIP and Medicare, you must make sure that you and each of your covered dependents is enrolled in Medicare Parts A and B **when first eligible for primary Medicare coverage**. If you fail to enroll in a timely manner, Medicare may impose a late enrollment premium surcharge and NYSHIP will not cover any expenses incurred by you or your dependent(s) that would have been covered by Medicare, had Medicare been in effect.

If you or a dependent is required to pay a premium for Medicare Part A coverage, contact the Employee Benefits Division. NYSHIP may continue to provide primary coverage for inpatient hospital expenses and you may delay enrollment in Medicare Part A until you become eligible for Part A coverage at no cost. See “Medicare Part A” in the second part of this book on page 63.

Domestic partner eligible for Medicare due to age (65)

When to Apply:

Plan ahead. Three months before your domestic partner turns age 65, contact the Social Security Administration to enroll in Medicare Parts A and B.

Medicare Parts A and B must be in effect on the first day of the month your domestic partner reaches age 65 (or, if your domestic partner’s birthday falls on the first of the month, in effect on the first day of the preceding month).

Note: 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 when Medicare becomes primary to NYSHIP.

When you or your dependent is Medicare-eligible due to end-stage renal disease

When to Apply:

If you or your dependent is eligible for Medicare due to end-stage renal disease, Medicare Parts A and B must be in effect on the first day following the completion of the 30-month coordination period.

Contact the Social Security Administration for Medicare information if you or your dependent is being treated for end-stage renal disease or expects to receive a kidney transplant.

Waiting period: A person diagnosed with end-stage renal disease must complete Medicare’s three-month waiting period before being eligible to enroll in Medicare. This waiting period may be waived by Medicare if the person:

- has enrolled in a self-dialysis training program within the three-month waiting period or
- receives a kidney transplant within the three-month waiting period.

30-month coordination period: Once the three-month waiting period has been completed or waived, a 30-month coordination period will begin. To avoid a penalty, Medicare must be in effect on the first day following the completion of the 30-month coordination period. Or, you or your dependent may choose to enroll in Medicare during the coordination period. You will not be reimbursed for any Medicare premiums or income-related monthly adjustment amount (IRMAA) during the coordination period because NYSHIP does not require Medicare to be in effect until the coordination period is complete and Medicare becomes primary to NYSHIP.

How to Apply for Medicare Parts A and B

You can sign up for Medicare Parts A and B by phone or by mail. Contact the Social Security Administration office at 1-800-772-1213. Or, you may visit your local Social Security Administration office. Information about applying for Medicare is also available on the web at www.ssa.gov.

Once you or your dependent is enrolled in Medicare, contact your Health Benefits Administrator and provide a copy of the Medicare ID card.

Order of Payment

When an individual is eligible for Medicare, CMS rules determine which plan is primary.

Benefits are paid in the following order:

1. coverage as a result of active employment
2. Medicare
3. retiree coverage

If you have questions about claims coordination with Medicare, contact the appropriate Empire Plan program administrator (see *Contact Information*, page 90).

Example 1: Sarah is employed by a Participating Employer and is covered under NYSHIP. She is over age 65 and is eligible for Medicare coverage, but because she is still working, NYSHIP provides her primary coverage. When Sarah receives covered services, NYSHIP should receive claims first, and Medicare second.

Example 2: Juliette is an active employee of a Participating Employer, and her husband, Peter, is a retiree from another employer that provides NYSHIP coverage. Both agencies participate in NYSHIP. Juliette is eligible for Medicare because she is over age 65. She has Individual coverage through her employer and is covered by Peter as a dependent on his retiree coverage. When Juliette goes to her doctor, claims are submitted to the NYSHIP coverage she has as an active employee first, then to Medicare, and then to the retiree NYSHIP coverage she has as Peter's dependent last.

Example 3: Will is over age 65 and is a retiree of a Participating Employer. Will's wife, Jane, is still actively working with an employer that provides NYSHIP coverage. Will is covered as a dependent on Jane's active coverage. When Will receives covered services, claims are first submitted to Jane's active NYSHIP coverage, then to Medicare, then to Will's retiree NYSHIP coverage last.

Additional Information for Medicare-Primary Enrollees and Dependents

If you or your dependent is Medicare primary due to end-stage renal disease or if your domestic partner is Medicare primary due to age, refer to the following sections on *Medicare and NYSHIP* in the portion of this book dedicated to retirees:

- "Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan for Empire Plan Enrollees," page 61
- "Medicare Costs, Payment and Reimbursement of Certain Premiums," page 62
- "Expenses Incurred Outside the United States," page 65
- "Provide Notice if Medicare Eligibility Ends," page 66

Questions

Call your Health Benefits Administrator if you have questions about:

- NYSHIP requirements, including when you must enroll in Medicare
- premium reimbursement
- whether and how enrolling in other coverage will affect your NYSHIP coverage
- which plan is responsible for paying claims

Call the Social Security Administration if you have questions about:

- your Medicare premium
- how to pay your Medicare premium
- how to enroll in Medicare
- whether you qualify for Medicare

Young Adult Option

The Young Adult Option allows the child of a NYSHIP enrollee to purchase Individual health insurance coverage through NYSHIP when the young adult does not otherwise qualify as a dependent.

Eligibility

To enroll in NYSHIP under the Young Adult Option, the young adult must be:

- a child, adopted child, child of a domestic partner* or stepchild of a NYSHIP enrollee (including those enrolled under COBRA)
- age 29 or younger
- unmarried
- not eligible for coverage through the young adult's own employer-sponsored health plan, provided that the health plan includes both hospital and medical benefits
- living, working or residing in the insurer's service area
- not covered under Medicare

**Children of a domestic partner are only eligible to enroll in the Young Adult Option if the employer extends eligibility for NYSHIP coverage to domestic partners.*

Eligibility for NYSHIP enrollment under the Young Adult Option ends when one of the following occurs:

- The young adult's parent is no longer a NYSHIP enrollee.
- The young adult no longer meets the eligibility requirements for the Young Adult Option as outlined above.
- The NYSHIP premium for the young adult is not paid in full by the due date or within the 30-day grace period.

The young adult has no right to COBRA coverage when coverage under the Young Adult Option ends.

Cost

There is no employer contribution toward the cost of the Young Adult Option. The young adult or his or her parent is required to pay the full cost of premium for Individual coverage.

Coverage

A young adult may enroll in any NYSHIP health plan for which the young adult is eligible. The young adult is not required to enroll in the same coverage option as the parent.

Enrollment Rules

Either the young adult or his or her parent may enroll the young adult in the Young Adult Option. Contact your employer for more information about how to pay for this coverage.

A young adult can enroll in the Young Adult Option at one of the following times:

- **When NYSHIP coverage ends due to age**

If the young adult no longer qualifies as a parent's NYSHIP dependent due to age, he or she can enroll in the Young Adult Option within 60 days of the date eligibility is lost. Coverage is retroactive to the date that the young adult lost coverage due to age. This is the only circumstance in which the Young Adult Option will be effective on a retroactive basis.

- **When newly qualified due to a change in circumstances**

If the young adult has a change of circumstances that allows him or her to meet eligibility requirements for the Young Adult Option, he or she can enroll in the Young Adult Option within 60 days of newly qualifying. Examples of a change of circumstances include a young adult's loss of employer coverage or the young adult's divorce.

- **During the Young Adult Option Open Enrollment Period**

Coverage may be elected during the Young Adult Option annual 30-day open enrollment period, which is determined by the employer. Contact the Employee Benefits Division for information about when this enrollment period will be and when your coverage will be effective.

When Young Adult Option Coverage Ends

Young Adult Option coverage ends on the last day of the month in which eligibility for coverage is lost or on the last day of the month in which voluntary cancellation is requested.

Questions

If you have any questions concerning eligibility, please contact your Health Benefits Administrator.



General Information Book

For Retirees, Vesteers and Dependent Survivors of Participating Employers

Refer to this portion of the book for information after you have retired or separated from service with a NYSHIP Participating Employer.

If you are still actively employed by a NYSHIP Participating Employer, including if you are receiving NYSHIP benefits while you are on a leave of absence, refer to the first part of this book, pages 2-41, for information.

When You Need Assistance

The Employee Benefits Division serves as the Health Benefits Administrator for retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions, COBRA enrollees and Young Adult Option enrollees.

For information about your enrollment, eligibility, Medicare coordination or any other aspect of NYSHIP, contact the Employee Benefits Division, Monday through Friday, 9 a.m. to 4 p.m. Eastern time, at 518-457-5754 or 1-800-833-4344 or by writing to:

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

Empire Plan inquiries: For questions on specific benefits or claims, or to locate a provider, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate program.

HMO inquiries: For questions on specific benefits or HMO services, or to locate a provider, call your HMO.

You are responsible for letting the Employee Benefits Division know of any changes that may affect your NYSHIP coverage.

When You Must Contact the Employee Benefits Division

The Employee Benefits Division and your retirement system are separate entities and do not share information. You must call your retirement system to update your record for retirement or pension purposes.

To keep your enrollment up to date, you must notify the Employee Benefits Division in writing (see “Model Letter for Contacting the Employee Benefits Division,” page 89) in the following situations:

Your mailing address changes or your home address changes (If you or a dependent is Medicare primary and your mailing address is a P.O. Box, the Employee Benefits Division will need your current residential address as well.)

Your phone number changes

Your name changes

You need to correct your enrollment record

Your family unit changes (see *Dependent Eligibility*, page 49 for details)

- You want to add or remove a covered dependent or change your type of coverage (Individual/Family)
- Your covered dependent loses eligibility
- Your covered dependent child becomes disabled
- You get divorced
- You or a dependent dies (a copy of the death certificate must be submitted)

Your employment status is changing

- You are returning to work for the same Participating Employer that provides your NYSHIP benefits
- You are awarded a disability retirement

Your Medicare status is changing

- You or a covered dependent loses eligibility for Medicare
- You or a covered dependent becomes eligible for Medicare benefits (See *Medicare and NYSHIP*, page 58)

Other reasons to contact the Employee Benefits Division

- Your employee benefit card is lost or damaged
- You have questions about the amount of your premium or your bill for NYSHIP coverage
- You want to cancel or reinstate your coverage
- You have questions about COBRA (see *COBRA: Continuation of Coverage*, page 69)

Retiree Benefits on the Web

You'll find NYSHIP Online, the NYSHIP homepage, on the New York State Department of Civil Service web site. Visit www.cs.ny.gov/retirees, then select Health Benefits. Copies of NYSHIP documents and informational materials are available on NYSHIP Online. Empire Plan enrollees will find links to Plan administrator web sites, which include the most current lists of participating providers.

Your Options Under NYSHIP

The Options

NYSHIP offers the following options:

- The Empire Plan
- a health maintenance organization (HMO) that has been approved for participation in NYSHIP in the geographic area where you live or work

Your Participating Employer may elect to offer only The Empire Plan or it may elect to offer both The Empire Plan and NYSHIP HMOs. Additionally, your employer may offer health plans outside of NYSHIP.

Most retirees, vestees, dependent survivors and enrollees covered under Preferred List provisions have prescription drug coverage through NYSHIP. Some retirees from certain Participating Employers have prescription drug coverage through a union Employee Benefit Fund.

For details about The Empire Plan and NYSHIP HMOs, refer to the *Choices* booklet, issued annually, usually in November or December, and contact the Employee Benefits Division if you have any questions about your NYSHIP options. If you did not receive a *Choices* booklet by mail in the fall, you may obtain one by visiting our web site or contacting the Employee Benefits Division.

The Empire Plan or a NYSHIP HMO

Regardless of whether you choose The Empire Plan or a NYSHIP HMO, your coverage provides you and your eligible dependents with all of the following:

- hospitalization and related expense coverage
- medical/surgical care coverage
- mental health and substance abuse treatment coverage
- prescription drug coverage

HMOs approved for participation in NYSHIP are not available in all areas. You must live or work in the HMO's service area. If you no longer meet the requirements of living or working in the HMO's service area, you must choose a different HMO that serves your new area or The Empire Plan. The benefits provided by The Empire Plan and NYSHIP HMOs differ. Be sure to choose the option that best meets your needs.

You and your dependents will have the same option. You, the enrollee, will determine the option for you and your covered dependents.

Changing Options

Once in a 12-month period, you may change to any NYSHIP option for which you are eligible for any reason.

There is no open enrollment period. If you and/or your dependents were previously eligible for NYSHIP coverage, but not enrolled, you must satisfy the late enrollment waiting period before coverage begins.

Each year, usually in November or December, you will be mailed a document called *Choices*, which contains information about the health insurance options available under NYSHIP. This document and other information is also available online. Go to www.cs.ny.gov/retirees and select Health Benefits, then Health Benefits & Option Transfer.

Contact the Employee Benefits Division to change your option. If you change options, the Employee Benefits Division will inform you of the date the new coverage will begin and the cost for that coverage.

Qualifying Events: Changing Options More Than Once During a 12-Month Period

You may change options more than once during a 12-month period **only** under the following circumstances:

- You are no longer eligible to continue coverage in your current HMO because you have moved permanently out of your HMO's service area or your job's location has changed and is no longer located in your HMO's service area. To keep NYSHIP coverage, you must choose a different HMO that serves your new area or The Empire Plan.
- You are eligible to enroll in an HMO that was not previously available to you, because you have moved permanently or your job's location has changed, and you want to change to an HMO that was not previously available. You may change to the new HMO regardless of what option you were in before you moved.
- Your dependent moves permanently and is no longer in your HMO's service area. (**Note:** A student attending college outside your HMO's service area is not considered a change in permanent residence.)
- You add a newly eligible dependent to your coverage in a timely manner. (See pages 54-55 for time frames.) The dependent may be acquired through marriage, domestic partnership, birth, adoption or placement for adoption or if your child meets "other" child eligibility criteria.
- You retire or vest your health insurance.

All requests to change options must be made in a timely manner, typically within 30 days of your qualifying life event, to ensure you have continued access to benefits.

Examples of requests that will not be permitted if you have made an option change within the last 12 months include, but are not limited to:

- Your doctor is no longer participating in your current plan's network, so you want to change to a plan with a network that your doctor is part of.
- Your current plan does not cover a procedure you need, so you want to change to a plan that does cover the procedure.
- You experience a change in your health and need to take new medications, so you want to change to an option with lower out-of-pocket prescription drug costs.
- Your financial situation changes, so you want to enroll in a less expensive option.
- Your child is attending college outside your HMO's service area, so you want to change to an option with a network in your child's area.

Consider Carefully

Be sure you understand how your benefits will be affected by changing options. By changing options, you could be getting substantially different coverage.

Retiree Coverage

Eligibility requirements for NYSHIP coverage as a retiree are outlined in the portion of this book for active employees, in *Eligibility to Continue Coverage as a Retiree* on page 29.

This section applies to those former employees who are already retired and have established eligibility to continue NYSHIP coverage as a retiree.

When You Retire

Your employer is responsible for determining and certifying your eligibility to continue coverage as a retiree. If your employer determines you are eligible, your employer may require you to pay a portion of the cost for your retiree coverage. The amount you pay to maintain your health coverage in retirement depends on a number of factors, including your:

- contribution rate
- health plan (The Empire Plan or HMO)
- type of coverage (Individual or Family coverage)

Also, you may be entitled to use the value of your unused sick leave to offset the cost of NYSHIP coverage in retirement. Contact the Employee Benefits Division to find out if this provision is available to you, and if so, how it will be applied.

Your employer is responsible for notifying you of the amount you must pay. In most cases, the cost of NYSHIP coverage will change annually when the premium changes.

How You Pay

As a retiree, your share of the premium for health insurance coverage, if any, is paid through deductions from your monthly retirement check or by making monthly payments directly to the Employee Benefits Division or to your former Participating Employer.

Suspending Enrollment

If you have other health insurance coverage and wish to discontinue your enrollment in NYSHIP, contact the Employee Benefits Division.

If you die while your coverage is not in effect, your dependents will have no rights to continue coverage as dependent survivors, under COBRA or through a direct-pay contract.

Canceling Coverage for Your Enrolled Dependent(s)

If your enrolled dependent is no longer eligible for NYSHIP coverage or you wish to cancel coverage for a covered dependent, contact the Employee Benefits Division. Your dependent may be eligible to continue coverage under COBRA (page 69), the Young Adult Option (page 73) or a direct-pay contract (page 72).

Reinstating Your Coverage as a Retiree

If you have established eligibility for retirement coverage and you suspend coverage, you may reinstate it at any time. To reinstate your coverage, submit a completed and signed *Health Insurance Transaction Form* (PS-404) to the Employee Benefits Division. If you are requesting coverage for your dependents, you must provide the required dependent proofs (see *Proof of Eligibility*, page 52, for a list of the required proofs that must be submitted with this request).

Under most circumstances, if you voluntarily suspend your coverage, you will be subject to a waiting period before your coverage becomes effective again. Ask for details about when coverage will become effective for you and any dependents you plan to enroll. Medical expenses incurred for services rendered during a waiting period (while you/your dependents are waiting for coverage to become effective) will not be covered.

Dependent* with Independent Eligibility for NYSHIP

If your covered dependent is an employee or former employee of a New York State agency, NYSHIP Participating Employer or NYSHIP Participating Agency and meets the eligibility requirements for NYSHIP coverage as an employee or retiree, your dependent maintains the right to reactivate his or her own NYSHIP enrollment at any time. For example, if you predecease your dependent, he or she may either continue in NYSHIP as a dependent survivor or reactivate enrollment in his or her own right.

**Rules for domestic partners in this book apply only if that coverage is offered by your employer.*

Other Resources

- Talk to the Employee Benefits Division. After you retire, the Employee Benefits Division will assist you with coverage and enrollment.
- To report certain enrollment changes or address changes, contact the Employee Benefits Division.
- Your *Empire Plan Certificate* and annual *At A Glance* booklet provide information about benefits and coverage for Empire Plan enrollees.
- The Department of Civil Service web site, www.cs.ny.gov/retirees, has current benefit information. Click on Health Benefits.
- *On the Road with The Empire Plan* is a handy guide to your Empire Plan benefits when traveling.
- Medicare is administered by the Social Security Administration. Call the Social Security Administration at 1-800-772-1213 to enroll in Medicare. For medical benefits and claims information, call 1-800-MEDICARE (1-800-633-4227) or visit the Medicare web site, www.medicare.gov.
- The *Medicare & NYSHIP* booklet and companion video explain how NYSHIP and Medicare work together to provide health benefits.
- *Medicare and NYSHIP* on page 58 of this book provides details on NYSHIP coordination of benefits with Medicare. Continue to use this book as a reference for NYSHIP policies after you retire.

Vestee Coverage

For information about eligibility and special rules for continuing NYSHIP coverage as a vestee (when you leave employment with your Participating Employer before you are eligible for coverage as a retiree), see *Vestee Coverage* on page 28 of the portion of this book for active employees.

If you have continued coverage as a vestee, contact the Employee Benefits Division to ensure that your coverage is changed when you qualify for retiree coverage. For information about when you will be eligible to continue NYSHIP coverage as a retiree, refer to the section *Eligibility to Continue Coverage as a Retiree* on page 29 of the portion of this book for active employees, and contact your former employer with questions.

Dependent Survivor Coverage

Enrolled dependents may be eligible to continue NYSHIP coverage if the enrollee predeceases them. See the following for dependent eligibility details.

To ensure that dependent survivors receive the benefits that they are entitled to, it is important to send a copy of the death certificate to the Employee Benefits Division as soon as possible after the enrollee's death. Notification to a retirement system does not satisfy this requirement.

Note: Survivors of COBRA enrollees are not eligible for the extended benefits period or dependent survivor coverage. Refer to the *COBRA: Continuation of Coverage* section starting on page 69 for information on coverage options.

Extended Benefits Period at No Cost

Dependents covered at the time of the enrollee's death will continue to receive coverage without charge for a period of three months beyond the last month for which the enrollee paid for NYSHIP coverage. This is referred to as the *extended benefits period*.

During the extended benefits period, enrolled Empire Plan dependents continue to use the health insurance benefit cards they already have under the enrollee's identification number. Enrolled dependents of HMO enrollees may receive a new card; contact your HMO for more information.

Eligibility for Dependent Survivor Coverage after the Extended Benefits Period Ends

For information regarding eligibility, cost and applying for dependent survivor coverage after the extended benefits period ends, contact the Employee Benefits Division.

To be eligible for dependent survivor coverage, the enrollee must have completed at least 10 years of benefits-eligible service, and the dependent must have been covered as the enrollee's dependent under NYSHIP at the time of the enrollee's death. If the enrollee's death was the result of a documented work-related injury, the 10-year service requirement is waived.

The following dependents covered at the time of the enrollee's death may be eligible for dependent survivor coverage:

- a spouse who has not remarried
- a domestic partner who has not married or acquired a new domestic partner (if the former employer provides coverage for domestic partners)
- dependent children who meet the eligibility requirements (see *Dependent Eligibility*, page 49)

Only dependents covered by the enrollee at the time of death or newborn children of the enrollee born after the enrollee's death are eligible for dependent survivor coverage. Each dependent survivor is eligible to continue NYSHIP coverage in his or her own right. Eligible dependent survivors may be enrolled in Individual coverage, Family coverage or a combination thereof.

A covered dependent who is not eligible for dependent survivor coverage may be eligible to continue NYSHIP coverage under COBRA (page 69) or may be eligible to convert to a direct-pay contract (page 72).

NYSHIP coverage will end permanently for eligible dependent survivors if they:

- do not make a timely election of dependent survivor coverage or
- fail to make the required payments

They may not reenroll.

Cost of Dependent Survivor Coverage

Contact the employer's Health Benefits Administrator for the cost of dependent survivor coverage.

Benefit Cards for Dependent Survivors

After the extended benefits period ends, the Employee Benefits Division will change the enrollment file to show the primary dependent survivor as the enrollee.

- Empire Plan enrollees: Dependent survivors will be mailed benefit information and a new Empire Plan benefit card with the survivor's name.
- HMO enrollees: Check with the HMO regarding benefits and new cards.

Dependent Eligible for NYSHIP as a Result of Employment

A dependent eligible through current employment or through previous employment with New York State, a NYSHIP Participating Employer or a NYSHIP Participating Agency may be eligible to reinstate coverage as an enrollee in NYSHIP. Coverage as an active employee or retiree may be less expensive than coverage as a dependent survivor.

Survivors who were previously employed by a Participating Employer or New York State should write to the Employee Benefits Division with details of relevant prior employment in order to determine if they are eligible to reinstate coverage as an enrollee. Survivors who were previously employed by a Participating Agency should write to the Participating Agency to ask about reenrollment.

Loss of Eligibility for Dependent Survivor Coverage

If your dependent loses eligibility for dependent survivor coverage, he or she may be eligible to continue coverage in NYSHIP under COBRA (see page 69) or convert to a direct-pay contract (see page 72).

Eligibility for dependent survivor coverage ends permanently if a:

- spouse remarries
- domestic partner acquires a new domestic partner or marries
- dependent child no longer meets the eligibility requirements (see pages 50-51)
- dependent survivor fails to make the required payments

If NYSHIP coverage as a dependent survivor is terminated for any reason, eligibility ends and the dependent is not eligible to reenroll.

If a surviving spouse or domestic partner loses eligibility or dies, eligible dependent children may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents.

Dependent Eligibility

You may cover your eligible dependents under NYSHIP by enrolling in Family coverage or by adding eligible dependents to existing Family coverage. The dependents meeting the requirements described in this section are eligible for NYSHIP coverage. As a retiree or vestee, you may add eligible dependents to your NYSHIP coverage. See pages 54-55 for information regarding when your dependents' coverage begins. Dependent survivors, see the previous section.

If your dependent is eligible for NYSHIP but not enrolled, contact the Employee Benefits Division for enrollment information.

See *Proof of Eligibility* on page 52 for required proofs that must be submitted with the request to add a dependent to your coverage.

For information about waiting periods when enrolling a dependent, see pages 54-55.

Note: Enrollees covered under the Young Adult Option are eligible for Individual coverage only; they may not cover their dependents. Refer to *Young Adult Option* on page 73 for information about eligibility under this option.

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.

Your Domestic Partner

Rules for domestic partners or children of domestic partners in this book apply only if that coverage is offered by your employer. If your employer does not offer coverage to domestic partners, your domestic partner is not eligible to be covered as your dependent under NYSHIP. Your domestic partner's child(ren) also may not be eligible, unless eligible as "other" children (see "Your 'other' child," page 51). Ask the Employee Benefits Division if your employer offers coverage to domestic partners.

If your employer does offer coverage to domestic partners, you may cover your domestic partner as your dependent. For eligibility under NYSHIP, a domestic partnership is one in which you and your partner are able to certify that you:

- are both 18 years of age or older,
- have been in the partnership for at least six months,
- are both unmarried (copy of divorce decrees or death certificates required, if applicable),
- are not related in a way that would bar marriage,
- have shared the same residence and have been financially interdependent for at least six months and
- have an exclusive mutual commitment (which you expect to last indefinitely) to share responsibility for each other's welfare and financial obligations.

To enroll a domestic partner, you must complete and return the forms *Application for Domestic Partner Benefits* (PS-425.1) and *Dependent Tax Affidavit for Domestic Partners* (PS-425.3) and submit the applicable proofs as outlined in *Instructions for Enrolling Domestic Partners* (PS-425). Before a new domestic partner may be enrolled, you will be subject to a one-year waiting period from the termination date of your last domestic partner's coverage.

Under Internal Revenue Service (IRS) rules, the fair market value cost of coverage for a domestic partner may be taxable. This amount, referred to as imputed income, is considered by the IRS to be additional income for the enrollee. Check with the Employee Benefits Division to find out how imputed income is reported and for an approximation of the fair market value for domestic partner coverage. You may also ask a tax consultant how enrolling a domestic partner will affect your taxes.

Your Children

The following children are eligible for coverage until age 26:

- your natural child
- your stepchild
- your domestic partner's child (if domestic partner coverage is offered by your employer)
- your legally adopted child, including a child in a waiting period prior to finalization of adoption
- your "other" child

Your “other” child

You may cover “other” children:

- who are financially dependent on you
- who reside with you
- for whom you have assumed legal responsibility in place of the parent

The above requirements must have been reached before the “other” child is age 19. You must file the form, *Statement of Dependence* (PS-457), verify eligibility and provide required documentation upon enrollment and every two years thereafter.

Your disabled child

You may cover your disabled child who is age 26 or older if the child:

- is unmarried
- is incapable of self-support by reason of mental or physical disability
- acquired the disabling condition before he or she would otherwise have lost eligibility due to age

Contact the Employee Benefits Division prior to your child’s 26th birthday (or 19th birthday for an “other” child with disability) to begin the review process. To apply for coverage for your disabled child, you must submit the form *Statement of Disability* (PS-451) and provide medical documentation. You will be asked to verify the continued disability, at minimum, every seven years (frequency based on disabling condition) by resubmitting the form and medical documentation. If a disabled dependent is also an “other” child, you will be required to resubmit the form *Statement of Dependence* (PS-457) every two years (at minimum) thereafter to verify continued disability.

Your child who is a full-time student with military service

For the purposes of eligibility for health insurance coverage as a dependent, you may deduct from your child’s age (between the ages of 19 and 25) up to four years for service in a branch of the U.S. Military. To be eligible, your dependent child must:

- return to school on a full-time basis,
- be unmarried and
- not be eligible for other employer group coverage.

You must be able to provide written documentation from the U.S. Military showing the dates of service. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required for verification.

Example: *Rebecca is 27 years old and served in the military from ages 19 through 23, then enrolled in college after the four years of military service. After deducting the four years of military service from her true age, her adjusted eligibility age is 23 (even though Rebecca is actually 27). As long as Rebecca remains a full-time student, she is entitled to be covered as a dependent until her adjusted eligibility age equals 26. In this example, Rebecca can be covered as a dependent for an additional three years, and when she reaches the adjusted eligibility age of 26, her actual age will be 30.*

In no event will any person who is in the armed forces of any country, including a student in an armed forces military academy of any country, be eligible for coverage.

Proof of Eligibility

Your application to enroll or to add a dependent to your coverage will not be processed by the Employee Benefits Division without the required proof of eligibility. Refer to *Retiree Coverage* (page 46), *Vestee Coverage* (page 47), *Dependent Survivor Coverage* (page 48) and *Dependent Eligibility* (page 49) for eligibility requirements.

Required Proofs

You must provide the following proofs to the Employee Benefits Division:

You, the enrollee

- birth certificate
- Social Security card
- Medicare card (if applicable)

Spouse*

- birth certificate
- marriage certificate
- proof of current joint ownership/joint financial obligation is also required (if the marriage took place more than one year prior to the request)
- Medicare card (if applicable)

Domestic partner**

- birth certificate
- completed forms in the *Domestic Partner Series* (PS-425), with appropriate proof as required in the application
- Medicare card (if applicable)

Natural-born children, stepchildren and children of a domestic partner**

- birth certificate
- Medicare card (if applicable)

Adopted children*

- adoption papers (if adoption is pending, proof of pending adoption)
- birth certificate
- Medicare card (if applicable)

Your disabled child over age 26*

- birth certificate
- completed form, *Statement of Disability* (PS-451) with appropriate documentation submitted to and approved by the plan administrator
- Medicare card (if applicable)

“Other” children*

(For more information about who qualifies as an “other” child, please refer to the section “Your Children” in *Dependent Eligibility*, page 50.)

- birth certificate
- completed form *Statement of Dependence* (PS-457) with appropriate documentation as required in the application
- Medicare card (if applicable)

Your child who is a full-time student over age 26 with military service*

- birth certificate
- adoption papers (if applicable)
- Medicare card (if applicable)
- written documentation from the U.S. Military showing dates of active service
- proof of full-time student status from an accredited secondary or preparatory school, college or other educational institution

* Provide the Social Security numbers of dependents when enrolling them for coverage.

** Not all employers offer coverage to domestic partners (see *Dependent Eligibility*, page 49). Contact the Employee Benefits Division for information.

Providing false or misleading information about eligibility for coverage or benefits is fraud.

Coverage: Individual or Family

Two types of coverage are available to you under NYSHIP: Individual coverage for yourself only or Family coverage for yourself and any eligible dependents you choose to cover.

Note: Young Adult Option enrollees are only eligible for Individual coverage.

Individual Coverage

Individual coverage provides benefits for you only. It does not cover your dependents, even if they are eligible for coverage.

If you do not enroll when first eligible, you may be subject to a late enrollment waiting period. Refer to “Effective date of coverage” in *Enrollment* on page 14 of the portion of this book for active enrollees for more information.

Family Coverage

Family coverage provides benefits for you and any eligible dependents you elect to enroll. For more information on who can qualify as your dependent, see *Dependent Eligibility*, page 49.

If you and your spouse are both eligible for coverage under NYSHIP, you may elect one of the following:

- one Family coverage
- two Individual coverages
- one Family coverage and one Individual coverage
- two Family coverages, if both of your employers permit two Family coverages (**Note:** New York State does not permit two Family coverages. If one spouse is enrolled as an employee of New York State, only one spouse may elect Family coverage. The other spouse may only elect Individual coverage.)

Changing Coverage

Changing from Individual to Family coverage

If you are changing to Family coverage because you acquired a new dependent (for example, you married), your new coverage will begin according to when you apply. **Note:** The time frame for covering newborns is different (see the following section, “Covering newborns”).

If you are changing Family coverage to add a dependent who was previously eligible but not enrolled, Family coverage will begin on the first day of the third month following the month in which you apply.

If you wish to change from Individual to Family coverage (and your dependents meet the requirements in *Dependent Eligibility*, page 49), contact the Employee Benefits Division. Be prepared to provide the following:

- your name, Social Security number, address and phone number
- the effective date and reason you are requesting the change (see the following for more information)
- your dependent’s name, date of birth and Social Security number
- a copy of the Medicare card, if your dependent is eligible for Medicare

Additional documentation may be required. See *Proof of Eligibility* on page 52.

The date your dependent’s coverage begins will depend on your reason for changing coverage and your timeliness in applying. You can avoid a waiting period by applying promptly.

You may change from Individual to Family coverage as a 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 the following section, “Covering newborns”).
- Your dependent’s other health insurance coverage ends.
- You return to the payroll after military leave, and you want to cover a dependent acquired during your leave.

Your dependent’s coverage will begin according to when you apply. If you apply:

- **7 days or less after a dependent’s first date of eligibility**, your Family coverage will be effective on the date the dependent was first eligible.
- **8–30 days after a dependent’s first date of eligibility**, there will be a waiting period. Family coverage will begin on the first day of the month following the month in which your request is made.
- **more than 30 days after a dependent’s first date of eligibility**, there will be a longer waiting period. Your Family coverage will become effective on the first day of the third month following the month in which you apply. If you apply on the first day of the month, that month is counted as the first month of the waiting period.

Covering newborns

Your newborn child is not automatically covered; you must contact the Employee Benefits Division to complete the appropriate forms. For additional documentation that may be needed, refer to *Proof of Eligibility* on page 52.

If you want to change from Individual to Family coverage to cover a newborn child and you request this change within 30 days of the child’s birth, the newborn’s coverage will be effective on the child’s date of birth.

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 in order for the coverage to be effective on the day the child was born.

If you already have Family coverage, you must also remember to add your newborn child within 30 days or you may encounter claim payment delays.

Adding a previously eligible dependent to existing Family coverage

To add a previously eligible but not yet enrolled dependent to your existing Family coverage, contact the Employee Benefits Division. Your previously eligible dependent's coverage will begin based on the timelines outlined in "Changing from Individual to Family coverage" on page 54.

Changing from Family to Individual coverage

It is your responsibility to keep your enrollment record up to date. If you no longer have any eligible dependents, you must change from Family to Individual coverage. You also may be able to make this change if you no longer wish to cover your dependents, even if they are still eligible.

Refer to the section *End Dates for Coverage*, page 68, for information about when your dependents' coverage ends if you change from Family to Individual coverage, or contact the Employee Benefits Division. For information about continuing dependent coverage, see *COBRA: Continuation of Coverage* on page 69 and *Young Adult Option* on page 73, or contact the Employee Benefits Division.

Enrollment Considered Late if Previously Eligible

If you or your dependent was previously eligible but not enrolled, coverage will begin on the first day of the third month following the month in which you apply.

Exception: Dependent affected by National Medical Support Order

If a National Medical Support Order requires you to provide coverage to your previously eligible but not enrolled dependent(s), the late enrollment waiting period is waived and coverage for your dependent(s) will be effective on the date indicated on the National Medical Support Order. You must contact the Employee Benefits Division and provide all of the following:

- a copy of the court order
- supporting documents showing that the dependent child is covered by the order
- supporting documents showing that the dependent child is eligible for coverage under NYSHIP eligibility rules (see *Proof of Eligibility*, page 52)

Exception: Changes in Children's Health Insurance Program (CHIP) or Medicaid eligibility

An employee or eligible dependent may enroll in NYSHIP if:

- coverage under a Medicaid plan or CHIP ends as a result of loss of eligibility or
- an employee or dependent becomes eligible for employment assistance under Medicaid or CHIP.

NYSHIP coverage must be requested within 60 days of the date of the change to avoid a waiting period.

Identification Cards

Empire Plan Enrollees

When you separate from State service, you will not be issued a new benefit card unless other changes to your coverage coincide with your change in status; you will continue to use the benefit card you used as an employee (refer to page 75 of the *Appendix* for a sample image of your Empire Plan benefit card).

There is no expiration date on your card. Use this card as long as you remain enrolled in The Empire Plan. This card includes your name and the names of your covered dependents. A separate card will be mailed to any dependent with a different address on your enrollment record.

Present your NYSHIP Empire Plan card before you receive services, supplies or prescription drugs.

The nine-digit number on your card is your Empire Plan identification number.

Your Empire Plan Medicare Rx card

If you or a dependent is enrolled in Empire Plan Medicare Rx, each person enrolled in Empire Plan Medicare Rx will receive a separate card for prescription drugs. Use this card whenever filling a prescription. (See “Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan for Empire Plan Enrollees” in *Medicare and NYSHIP*, page 61.)

Ordering a card

Contact the Employee Benefits Division to order a NYSHIP Empire Plan benefit card if your card (or a dependent’s) is lost or damaged. Your new card will be sent to the address on your enrollment record. Please confirm that your address is correct. You can also order a new card at MyNYSHIP by going to www.cs.ny.gov/mynyship.

If you need to order an Empire Plan Medicare Rx card, call the Prescription Drug Program and follow the prompts for Empire Plan Medicare Rx (see *Contact Information*, page 90).

HMO Enrollees

Upon enrollment in a NYSHIP HMO, you will receive a NYSHIP HMO card. When Medicare becomes primary for you or your dependent, you may also receive a new benefit card and/or an additional prescription drug card. If you have any questions concerning your card, including how to order a new one, contact your HMO.

Possession of a Card Does Not Guarantee Eligibility

Do not use your card before coverage becomes effective or after eligibility ends. To verify eligibility dates, contact the Employee Benefits Division. Use of a benefit card when you are not eligible may constitute fraud. If you or your dependent uses the card when you are not eligible for benefits, you will be billed for all claims paid incorrectly on behalf of you or your dependents.

You are responsible for notifying the Employee Benefits Division immediately when you or your dependents are no longer eligible for NYSHIP coverage. You must submit this notice in writing with your signature (see “Model Letter for Contacting the Employee Benefits Division” on page 89 of the *Appendix*).

Your Premium

Note: Payment of premium does not establish eligibility for NYSHIP benefits. You must satisfy NYSHIP eligibility requirements.

After your former employer's contribution, you are responsible for paying the balance of your premium, if any, through deductions from your retirement check or by direct payments to the Employee Benefits Division or directly to your former employer.

Retirees

Your former employer must pay a portion of your health insurance coverage. For Individual coverage, your employer must contribute a minimum of 50 percent of the premium. For Family coverage, your employer must contribute a minimum of 50 percent of your premium as the enrollee, plus 35 percent of the additional cost of dependent coverage, regardless of the number of dependents.

Most retirees pay a portion of their NYSHIP health insurance premium. The amount you pay to maintain your health coverage in retirement depends on a number of factors, including your:

- health insurance option (Empire Plan or HMO)
- type of coverage (Individual coverage or Family coverage)
- sick leave credit, if applicable

The Employee Benefits Division will notify you of the monthly amount you must pay, or advise you of who to contact for this information.

Rate Information

Premium rates for The Empire Plan and NYSHIP HMOs are available on the Department of Civil Service web site at www.cs.ny.gov/retirees, under Health Benefits & Option Transfer. Usually in November or December, you will receive a flyer that lists some of the most common rates for each NYSHIP option for the upcoming Plan year. Contact the Employee Benefits Division if you have any questions about the cost of your health insurance.

Vestees, Young Adult Option Enrollees

Vestees and Young Adult Option enrollees pay both the employer and employee shares of the premium. There is no employer contribution toward the cost of coverage. Refer to *Vestee Coverage*, page 47, or *Young Adult Option*, page 73, for more information.

Dependent Survivors

Contact the Employee Benefits Division for the cost of coverage.

Military Active Duty

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 dependents will be eligible for coverage if you had Family coverage for at least 30 days before your activation. To arrange for this benefit if you are going on active military duty, you or a family member must contact the Employee Benefits Division and provide documentation of the dates you were called to active duty. You may be required to pay the full cost of the premium.

Medicare and NYSHIP

NYSHIP requires enrollees and covered dependents to enroll in Medicare Parts A and B when Medicare coverage is primary to NYSHIP coverage. You must follow NYSHIP rules to ensure that your coverage is not reduced or canceled. Do not depend on Medicare, your provider, another employer or your health plan for information about NYSHIP, since they may not be familiar with NYSHIP's rules. A change in Medicare's rules could affect NYSHIP's requirements.

COBRA enrollees: There are special rules for COBRA enrollees. Read "Medicare and COBRA" in *COBRA: Continuation of Coverage* on page 70 to determine if information in this section will apply to you.

Medicare: A Federal Program

This section provides a brief overview of Medicare. Check www.medicare.gov for complete and current information about Medicare.

Medicare is the federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people age 65 and older, and for those under age 65 with certain disabilities.

If you have questions about Medicare eligibility, enrollment or cost, contact the Social Security Administration at 1-800-772-1213, 24 hours a day, seven days a week. TTY users should call 1-800-325-0778. Or, check the web site, www.ssa.gov.

For questions about Medicare benefits, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare's web site, www.medicare.gov, also has information.

Medicare Part A* covers inpatient care in a hospital or skilled nursing facility, hospice care and home health care.

Medicare Part B* covers doctors' services, outpatient hospital services, durable medical equipment and some other services and supplies not covered by Part A and certain prescription drugs in specific situations.

**Medicare Parts A and B are referred to as "original Medicare."*

Medicare Advantage plans, formerly referred to as Medicare Part C, have a contract with CMS to provide Medicare Parts A and B, and often Medicare Part D prescription drug coverage, as part of a plan that provides comprehensive health coverage.

Medicare Part D is the Medicare prescription drug benefit. Medicare Part D plans can either be part of a comprehensive plan that provides hospital/medical coverage or a standalone plan that provides only prescription drug benefits.

Combination of Medicare and NYSHIP Protects You

When you become eligible for Medicare that is primary to NYSHIP as a retiree, vestee, Preferred List enrollee or dependent survivor enrolled in NYSHIP coverage, or when your enrolled dependent becomes eligible for Medicare that is primary to NYSHIP, the combination of health benefits under Medicare and NYSHIP provides the most complete coverage. To maximize your overall level of benefits, it is important to understand:

- NYSHIP's requirements for enrollment in Medicare Parts A and B
- how Medicare and NYSHIP work together
- how enrolling for other Medicare coverage may affect your NYSHIP coverage

NYSHIP requires you to enroll in Medicare Parts A and B when first eligible for Medicare coverage that is primary to NYSHIP. **Primary means Medicare pays health insurance claims first, before NYSHIP.** NYSHIP also requires your dependents to be enrolled in Medicare Parts A and B when they are first eligible for primary Medicare coverage. Therefore, references to "you" and Medicare enrollment apply to both you and your covered dependents.

Since NYSHIP becomes secondary to Medicare Parts A and B as soon as you are eligible for primary Medicare coverage, if you fail to enroll in Medicare or are still in a waiting period for Medicare to go into effect, you will be responsible for hospital and medical expenses that Medicare would have covered if you had enrolled in a timely manner.

If you return to work for the same employer that provides your NYSHIP retiree coverage, be sure to read *Reemployment* on page 67.

Empire Plan

When Medicare is primary to The Empire Plan for you and/or your covered dependents, The Empire Plan will coordinate hospital, medical and mental health and substance abuse benefits with your traditional Medicare Parts A and B coverage. Your prescription drug coverage will be provided under Empire Plan Medicare Rx, a Medicare Part D plan with enhanced benefits. Refer to “Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan for Empire Plan Enrollees” on page 61 of this section.

HMO enrollees

When Medicare becomes primary for you and/or your covered dependents, most NYSHIP HMOs will automatically enroll you in the HMO’s Medicare Advantage plan. This means your HMO will provide both your Medicare and NYSHIP benefits. Your HMO will provide you with information regarding benefit changes and identification cards.

If you are enrolled in an HMO that coordinates benefits with Medicare, your coverage will be provided through a combination of traditional Medicare Parts A and B and HMO coverage. Your HMO will provide you with information regarding any changes in your benefits or cards.

To find out whether you will be enrolled in a Medicare Advantage plan or whether your HMO will coordinate with Medicare when Medicare becomes primary to NYSHIP, contact your HMO.

When Medicare Eligibility Begins

You are eligible for Medicare:

- at age 65,
- regardless of age, after receiving Social Security Disability Insurance (SSDI) benefits for 24 months,
- regardless of age, after completing Medicare’s waiting period of up to three months due to end-stage renal disease (ESRD) or
- when receiving SSDI benefits due to amyotrophic lateral sclerosis (ALS).

When Medicare Becomes Primary to NYSHIP

Medicare becomes primary to NYSHIP when:

1. you no longer have NYSHIP coverage as the result of active employment (for example, you are covered as a retiree, vestee, Preferred List enrollee or dependent survivor, or you are covered as the dependent of one of these enrollees) **and**
2. you are eligible for Medicare

There are **two exceptions to this primacy rule**:

- End-stage renal disease: If you or your dependent is eligible for Medicare due to end-stage renal disease, contact Medicare at the time of diagnosis. Medicare becomes primary to NYSHIP when Medicare’s 30-month coordination period is completed.
- Domestic partners: Regardless of the employment status of the enrollee, Medicare is primary for a domestic partner age 65 or older.

When You are Required to Have Medicare Parts A and B in Effect

The rules in this section apply to you if you live in one of the 50 United States or Puerto Rico, Guam, the U.S. Virgin Islands, Northern Marianas or American Samoa. If you reside outside the United States or its territories, refer to “Residing outside the United States,” page 65.

The responsibility is yours: To avoid a reduction in the combined overall benefits provided under NYSHIP and Medicare, you must make sure that you and each of your covered dependents is enrolled in Medicare Parts A and B **when first eligible for primary Medicare coverage**. If you fail to enroll in a timely manner, Medicare will impose a late enrollment premium surcharge, and NYSHIP will not cover any expenses incurred by you or your dependent that would have been covered by Medicare, had Medicare been in effect.

If you or a dependent is required to pay a premium for Medicare Part A coverage, contact the Employee Benefits Division. NYSHIP may continue to provide primary coverage for inpatient hospital expenses and you may delay enrollment in Medicare Part A until you become eligible for Part A coverage at no cost (see “Medicare Part A” on page 63).

When you are Medicare-eligible due to age (65)

When to Apply:

Plan ahead.
Three months
before you turn
age 65, contact
the Social Security
Administration to
enroll in Medicare
Parts A and B.

Medicare Parts A and B must be in effect on the first day of the month you/your dependent reaches age 65 (or, if your birthday falls on the first of the month, in effect on the first day of the preceding month).

Note: 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 when Medicare becomes primary to NYSHIP.

Note: If you get married and your spouse is age 65 or older, your spouse must be enrolled in Medicare Parts A and B. Be sure that Medicare is in effect beginning the date of the marriage.

When you are Medicare-eligible due to disability

When to Apply:

Be sure that
Medicare is in
effect when you
are eligible for
Medicare-primary
coverage due to
disability. Contact
the Social Security
Administration to
find out when this
date will be.

If you or a covered dependent becomes eligible for Medicare due to disability prior to age 65 (refer to “When Medicare Eligibility Begins” on page 59 of this section), you/your dependent must have Medicare Parts A and B coverage in effect on the first day of eligibility for Medicare coverage that is primary to NYSHIP. In most cases, this will be the first date of Medicare eligibility.

If you are already receiving Social Security benefits, you may automatically be enrolled in Medicare Parts A and B by the Social Security Administration. However, it is your responsibility to ensure that your Medicare coverage is in place when Medicare is primary to NYSHIP.

If you or your dependent is eligible for Medicare due to end-stage renal disease, Medicare Parts A and B must be in effect on the first day following the completion of the 30-month coordination period.

End-stage renal disease

Special rules apply to people who have been diagnosed with end-stage renal disease. Contact Social Security for Medicare information if you or your dependent is being treated for end-stage renal disease or if you expect to receive a kidney transplant.

Waiting period: A person diagnosed with end-stage renal disease must complete Medicare's three-month waiting period before being eligible to enroll in Medicare. This waiting period may be waived by Medicare if the person:

- has enrolled in a self-dialysis training program within the three-month waiting period or
- receives a kidney transplant within the three-month waiting period.

30-month coordination period: Once the three-month waiting period has been completed or waived, a 30-month coordination period will begin. To avoid a penalty and reduction or cancellation of your NYSHIP benefits, Medicare must be in effect on the first day following the completion of the 30-month coordination period. Or, you or your dependent may choose to enroll in Medicare during the coordination period. You will not be reimbursed for any Medicare premiums or income-related monthly adjustment amount (IRMAA) during the coordination period because NYSHIP does not require Medicare to be in effect until the coordination period is complete and Medicare becomes primary to NYSHIP.

How to Apply for Medicare Parts A and B

The Social Security Administration may send you a Medicare card with an option to decline enrollment in Part B. **Do not decline.** If you declined Part B when the Social Security Administration offered it to you, enroll now and send a photocopy of your new card to the Employee Benefits Division.

You can sign up for Medicare Parts A and B by phone or by mail. Contact the Social Security Administration office at 1-800-772-1213. Or, you may visit your local Social Security Administration office. Information about applying for Medicare is also available on the web at www.ssa.gov.

Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan for Empire Plan Enrollees

Prescription drug coverage for Medicare-primary Empire Plan enrollees and dependents

When you and your enrolled dependents become Medicare primary, each of you is automatically enrolled in Empire Plan Medicare Rx, a Medicare Part D prescription drug program designed especially for The Empire Plan. Enrollment in Empire Plan Medicare Rx is required in order for you to continue your coverage in The Empire Plan. You do not have the option to decline enrollment in Empire Plan Medicare Rx. Exceptions apply; see the following.

You and your enrolled dependents will each begin to receive notices and publications about Empire Plan Medicare Rx as your Medicare eligibility date approaches. When you receive your information packet, you will be given the option to decline enrollment in Empire Plan Medicare Rx, as required by CMS. **If you decline Empire Plan Medicare Rx, you will cancel all Empire Plan coverage, including hospital, medical/surgical, mental health and substance abuse and prescription drug benefits.** If you are the enrollee, Empire Plan coverage for you and each of your covered dependents will end. If you are covered as a dependent, only your coverage will be canceled.

The Empire Plan Prescription Drug Program administrator will attempt to enroll you automatically in Empire Plan Medicare Rx. If you have other retiree coverage through a spouse, please refer to the following section, “Other Medicare prescription drug plans.” Although in most cases you are not required to take any action, contact the Employee Benefits Division immediately if:

- your automatic enrollment is rejected by CMS (for example, because you have no physical address on record) or
- you are later disenrolled because you enrolled in another Medicare Part D plan or another Medicare product.

If your enrollment is rejected or if you are disenrolled, you will receive information from the Prescription Drug Program administrator.

Also contact the Employee Benefits Division if you or your dependent is:

- receiving Extra Help for your Empire Plan Medicare Rx benefit,
- confined in a skilled nursing facility or
- disabled and enrolled in an approved Medicare Special Needs Plan (SNP) or Medicaid

Other Medicare prescription drug plans

Under Medicare rules, you can be enrolled in only one Medicare plan at a time. If you enroll in another Medicare Part D plan or another Medicare product after you are enrolled in Empire Plan Medicare Rx, Medicare will cancel your enrollment in Empire Plan Medicare Rx and all Empire Plan coverage—your hospital, medical/surgical, mental health and substance abuse services—will end. If you are the enrollee, Empire Plan coverage for you and each of your covered dependents will end. If you are covered as a dependent, only your coverage will be canceled. This may occur because you or your dependent:

- is covered as a dependent in another plan
- has additional coverage through another employer
- is enrolled in a standalone Medicare plan

Other Medicare plans could include products that you or your covered dependents are enrolled in through another employer (yours or your spouse’s). Be sure to understand how enrolling for additional Medicare coverage will affect your overall benefits. If you have questions about how your Empire Plan benefits may be affected by enrolling in another plan, contact The Empire Plan or the Employee Benefits Division.

Empire Plan Medicare Rx ID card

Every Medicare-primary Empire Plan enrollee and every Medicare-primary dependent receives a separate, individualized prescription drug ID card (refer to page 75 of the Appendix for an example). Each card provides a new unique ID number to be used at a network pharmacy when filling your prescription medications. You will receive this card and other Empire Plan Medicare Rx material from the Prescription Drug Program administrator.

Keep your Empire Plan benefit card(s) for other benefits

Continue to use your Empire Plan benefit card (see *Identification Cards*, page 56) for all other Empire Plan benefits, including hospital services, medical/surgical services, mental health and substance abuse services and prescriptions covered under Medicare Part B. Enrollees and dependents who are not Medicare primary will continue to use their Empire Plan benefit card for prescriptions.

Medicare Costs, Payment and Reimbursement of Certain Premiums

When you are required to enroll in Medicare (as explained in “When You are Required to Have Medicare Parts A and B in Effect” on page 60 of this section), you will be subject to a premium for Medicare Part B, and, in some cases, you will also be responsible for other Medicare premiums. Each year, the Social Security Administration will send you a letter that explains what your cost for Medicare will be for the coming plan year.

Medicare Part A

For most people, there is no premium for Medicare Part A coverage.

If you or your dependent does not meet certain Social Security requirements, you may be required to pay a premium for Medicare Part A. In these cases, NYSHIP does not require enrollment in Medicare Part A. If you choose to enroll, NYSHIP will not reimburse you for the Medicare Part A premium. Be sure to call the Employee Benefits Division to confirm that you are not required to enroll; if you mistakenly decline enrollment in Medicare Part A, it could be very costly to you.

Medicare Part B premium

Standard Medicare Part B premium

The standard Medicare Part B premium may change annually. You and any covered dependents enrolled in Medicare will be responsible for a Medicare Part B premium for your coverage when Medicare is primary to NYSHIP. The amount of the standard Medicare Part B premium is available at www.medicare.gov.

Medicare Part B IRMAA

In addition to the standard premium for Medicare Part B, Medicare enrollees with a higher modified adjusted gross income (MAGI) pay an additional income-related monthly adjustment amount (IRMAA), a Medicare premium amount adjusted for their income, for Part B coverage. If you are required to pay a Medicare Part B IRMAA, that amount will be included in your annual Social Security award letter. NYSHIP is required to reimburse you for this amount if you are eligible for reimbursement under NYSHIP rules (see “Medicare Part B IRMAA reimbursement” on page 64 of this section).

If you do not pay your Medicare Part B IRMAA, your Medicare Part B coverage will be canceled and your NYSHIP coverage will be drastically reduced.

How you pay

You will pay premiums for Medicare Part B in one of three ways:

- deductions from your Social Security benefits
- deductions from your Railroad Retirement Board pension
- direct payments to the Social Security Administration

Medicare Part B premium reimbursement

When you or your dependent is required to enroll in Medicare (as described in “When You are Required to Have Medicare Parts A and B in Effect” on page 60 of this section), NYSHIP will reimburse you the Medicare Part B premium and Medicare Part B IRMAA. You are not entitled to a reimbursement if:

- you receive reimbursement from another source or
- the premium is being paid on your behalf by another entity (such as Medicaid)

You are required to notify the Employee Benefits Division if either of the above circumstances applies to you.

NYSHIP will not reimburse any late enrollment penalties assessed by Medicare. If you choose to enroll in Medicare when you are eligible but not required to enroll under NYSHIP rules (i.e, Medicare is not primary to NYSHIP), NYSHIP will not reimburse the Medicare Part B premium or any IRMAA.

If you or your dependent is over age 65 and required to enroll in Medicare, you will be reimbursed for the standard Medicare Part B premium and IRMAA. Contact the Employee Benefits Division to apply for reimbursement.

Standard Medicare Part B premium reimbursement

The Medicare Part B standard premium will be reimbursed in one of the following ways:

- *Credits applied to pension check:* If you receive a pension check, any reimbursement for Medicare Part B will be included in the check. If your pension is direct deposited, this amount will appear in the cell labeled “Medicare Credit,” under the heading “Health Insurance” on the *Notice of Change* document. If you receive a check, it will be shown as a Medicare credit on your retirement check stub (see samples on pages 78 and 79 of the *Appendix*).
- *Credits applied to monthly bills from the Employee Benefits Division:* If you make direct payments to the Employee Benefits Division, reimbursements will be credited toward your monthly NYSHIP premium payments. If your Medicare reimbursement exceeds your health insurance premium, the Office of the State Comptroller will issue you a quarterly refund for the difference.
- *Credits applied to beneficiary checks for dependent survivors:* Dependent survivors can request to receive reimbursement as a credit on the beneficiary checks from the New York State and Local Employees’ Retirement System or Teachers’ Retirement System. (Dependent survivors who make direct payments to the Employee Benefits Division will receive reimbursement as a credit toward monthly premiums or as a quarterly refund.)

Medicare Part B IRMAA reimbursement

Contact the Employee Benefits Division to apply for Medicare Part B IRMAA reimbursement. You will be required to provide:

- a copy of the letter the Social Security Administration sent to notify you of the amount you are responsible for paying and
- proof of payment; for example, a copy of SSA-1099 (the Social Security Administration will provide this to you in January for payments made the prior year) or copies of billing statements from CMS

Medicare Part D

The Empire Plan and many NYSHIP HMO Medicare Advantage plans provide Medicare Part D coverage as a component of your health plan. Therefore, the standard Medicare Part D premium is a component of your total Empire Plan premium. However, you may be responsible for a Medicare Part D IRMAA, a higher premium based on income. If you do not pay the Medicare Part D IRMAA, Medicare will cancel your Medicare Part D coverage, which will result in the cancellation of your NYSHIP coverage, including your dependents’ coverage if you have Family coverage. Neither NYSHIP nor your former employer is required to reimburse Medicare Part D IRMAA.

Your Claims When Medicare is Primary

When Medicare and NYSHIP are your only coverage

Benefits are paid in the following order:

1. Medicare
2. NYSHIP (Empire Plan or HMO)

If you have questions about claims coordination with Medicare, contact the appropriate Empire Plan program administrator (see *Contact Information*, page 90) or contact your HMO.

If you are enrolled in a NYSHIP HMO that offers a Medicare Advantage plan, the HMO provides your Medicare benefits and there is no coordination of coverage between Medicare and NYSHIP.

Example 1: Juliette is an active employee of an agency, and her husband, Paul, is a retiree from a different agency. Both agencies participate in NYSHIP. Juliette is eligible for Medicare because she is over age 65. She has Individual coverage through her employer and is covered by Paul as a dependent on his retiree coverage. When Juliette goes to her doctor, claims are submitted to the NYSHIP coverage she has as an active employee first, then Medicare, and then to the retiree NYSHIP coverage she has as Paul's dependent last.

Example 2: Marie is a retiree and has NYSHIP retiree coverage through her former employer. Marie's husband, Jose, is a retiree from a different employer, and also has retiree coverage through NYSHIP. Jose has Family coverage and covers Marie as his dependent. In addition, Marie is eligible for Medicare because she receives SSDI benefits due to amyotrophic lateral sclerosis (ALS). When Marie is admitted into the hospital, claims are submitted to Medicare first, then to the NYSHIP coverage she has as a retiree, then to the NYSHIP coverage she has as a dependent of Jose, also a retiree.

Example 3: Will is over age 65 and is a retiree of a Participating Employer. Will's wife, Susan, is still actively working with an employer that provides NYSHIP coverage. Will is covered as a dependent on Susan's active coverage. When Will receives covered services, claims are first submitted to Susan's active NYSHIP coverage, then to Medicare, then to Will's retiree NYSHIP coverage last.

When you have coverage in addition to Medicare and NYSHIP

If you and/or your dependent also has coverage as an active employee through an employer, the active employee coverage through that plan pays before Medicare.

If you or your spouse has group coverage as a retiree through another employer, refer to the materials provided by each plan and contact your health plan for details regarding coordination of benefits.

Expenses Incurred Outside the United States

Medicare does not cover medical expenses incurred outside the United States.

Traveling outside the United States

Empire Plan enrollees

For covered services received outside the United States, file claims directly with The Empire Plan (see *Contact Information*, page 90). For more information, refer to your *Empire Plan Certificate* and the publication *On The Road With The Empire Plan*.

HMO enrollees

Check with your HMO regarding coverage for services received outside the United States.

Residing outside the United States

If you reside outside the United States, The Empire Plan is your only available coverage through NYSHIP. If you will be residing outside the United States, you must notify the Employee Benefits Division. In most cases, Medicare will not cover services received outside of the United States. Refer to your plan *Certificate* for information about covered services and coordination of benefits.

If your permanent residence is outside the United States, enrollment in Medicare is not required by NYSHIP.* In most cases, Medicare Part B premium reimbursement will end if you choose to reside outside the United States.

If you choose to enroll in Medicare while you reside outside the United States:

- Your former employer will reimburse Medicare Part B premiums upon application, but only for the months during which you received services in the United States. In limited circumstances, enrollees residing outside the United States but routinely receiving care in the United States will not be required to apply for Medicare Part B premium reimbursement each month.

- If you return temporarily to the United States for medical treatment, Medicare provides primary coverage. Contact the Employee Benefits Division for information on Medicare premium reimbursement and assistance with claims adjudication.

For information about filing claims, refer to your *Empire Plan Certificate* and the publication *On The Road with The Empire Plan*.

***Note:** *If you do not enroll or choose to disenroll from Medicare while residing outside the United States, you will be assessed a late enrollment penalty by the Social Security Administration if you enroll in Medicare at a later date (refer to “When You are Required to Have Medicare Parts A and B in Effect” on page 60 of this section).*

Returning permanently to the United States

If you permanently move back to the United States and you maintained Medicare Part B coverage, notify the Employee Benefits Division of your new address. Ask that your Medicare Part B premium reimbursement resume.

If you permanently move back to the United States and did not maintain Medicare Part B coverage, you should do the following:

- Contact the Social Security Administration for information about how and when you can establish Medicare coverage. If Medicare coverage will not be in effect at the time you return to the United States, contact the Employee Benefits Division.
- Contact the Employee Benefits Division when you return and provide your new address and a copy of your current Medicare card. Ask the Employee Benefits Division to resume reimbursement for Medicare Part B premiums and IRMAA when you provide proof of Medicare Part B enrollment.

Provide Notice if Medicare Eligibility Ends

If Medicare eligibility ends for you or your dependent, you must notify the Employee Benefits Division.

You must refund Medicare premium reimbursement you were not eligible to receive

If you receive reimbursement for Medicare Part B premiums or IRMAA for yourself or a dependent when you are not eligible or when the premiums are reimbursed by another source, you will be required to repay amounts that were incorrectly reimbursed.

Questions

Call the Employee Benefits Division if you have questions about:

- NYSHIP requirements, including when you must enroll in Medicare
- premium reimbursement
- whether enrolling in other coverage will affect your NYSHIP coverage
- which plan is responsible for paying claims

Call the Social Security Administration if you have questions about:

- your Medicare premium
- how to pay your Medicare premium
- how to enroll in Medicare
- whether you qualify for Medicare

Reemployment

With the Employer You Retired From

Returning to work in a benefits-eligible position with the employer that provides your NYSHIP retiree benefits is a change that may affect your coverage. Before you are reemployed, talk to the Health Benefits Administrator from your former agency about the following:

- *Choosing active or retiree coverage:* If you are eligible for NYSHIP as both an active employee and as a retiree, you must choose one; you cannot have coverage as both an active employee and a retiree (see *Coverage: Individual or Family*, page 53).
- *Medicare:* If you are reemployed by the employer that provides your retiree benefits, NYSHIP will provide coverage primary to Medicare during the time that you are working in a benefits-eligible position with that employer. If you were Medicare primary prior to reemployment, this change may affect your premium and coverage. You will not receive Medicare reimbursement while working in a benefits-eligible position. This applies regardless of whether you continue enrollment as a retiree or enroll in active employee coverage.

With an Employer that Participates in NYSHIP

If you are eligible for NYSHIP as a retiree and subsequently are hired in a benefits-eligible position with another employer that participates in NYSHIP, you will need to make certain decisions about your coverage. Before you accept employment, talk to the Health Benefits Administrators at both employers about the following:

- *Choosing active or retiree coverage:* If you are eligible for NYSHIP through both your current and former employer, you must choose one to provide your NYSHIP coverage; you cannot enroll through both. Carefully discuss this decision with the Health Benefits Administrators at both employers; the cost of coverage may be different at each employer.
- *Medicare:* Your Medicare status will be affected differently depending on whether you choose to enroll in coverage as an employee or continue enrollment as a retiree.
 - If you choose to maintain your NYSHIP retiree coverage, Medicare will continue to be primary to NYSHIP after you are employed. NYSHIP will continue to be responsible for reimbursing the Medicare Part B premium to you.
 - If you choose to enroll in NYSHIP as an employee, NYSHIP will be your primary coverage while you are working in a benefits-eligible position with that employer. If you were Medicare primary prior to reemployment, this change may affect your premium and coverage, and you will no longer receive any Medicare reimbursement.

With a Non-NYSHIP Employer

If you are eligible for NYSHIP as a retiree and subsequently are hired in a benefits-eligible position with another employer that does not participate in NYSHIP, you can choose to remain covered as a NYSHIP retiree. Your NYSHIP Medicare status will not change. If you wish to enroll for coverage with the non-NYSHIP employer and maintain your NYSHIP retiree coverage, your coverage through active employment will be primary to Medicare.

End Dates for Coverage

You, the Enrollee

Loss of eligibility

If you lose eligibility for NYSHIP coverage, coverage will end on the last day of the month in which you lost eligibility. If you are enrolled in Family coverage and you lose eligibility, your dependents' coverage ends on the same date your coverage ends. Contact the Employee Benefits Division with questions about the exact date coverage will end.

Suspending retiree coverage

If you choose to suspend your retiree coverage, your coverage will end on the last day of the last month that you paid the NYSHIP premium.

Consequences

If you die while your coverage is canceled or suspended, your dependents will have no right to continue coverage as dependent survivors.

If you cancel your enrollment while you are in vestee status, you will not be eligible to reenroll in NYSHIP as a vestee unless you have maintained continuous NYSHIP coverage elsewhere.

Dependent Loss of Eligibility

Contact the Employee Benefits Division as soon as your dependent no longer qualifies for coverage.

If you choose to change from Family to Individual coverage when your dependents are still eligible, coverage for your dependents will end on the last day of the month in which you request this change.

Children

Coverage for most dependent children ends on the last day of the month in which the child reaches age 26 (or an adjusted age 26 for dependent children with qualifying military service [see page 51]). Coverage for your former spouse's children will end on the date of divorce, and coverage for your domestic partner's children will end on the effective date of the dissolution of domestic partnership. In certain cases, coverage ends when the child no longer meets specific eligibility requirements (refer to "Your disabled child" and "Your 'other' child" on page 51 for special eligibility requirements). Your child up to age 30 may be eligible to enroll in NYSHIP coverage under the Young Adult Option (see page 73).

Children who lose eligibility and then reestablish dependent eligibility may reenroll. Unmarried, disabled dependent children who lost eligibility can be covered under NYSHIP if the same disability that qualified them as disabled dependents while they were enrolled in NYSHIP again renders them incapable of self-support. Appropriate documentation will be required.

Former spouse

Coverage ends for your former spouse on the date that the judgment of divorce is entered (filed) with the clerk of the court.

Former domestic partner

Coverage ends for your former domestic partner on the effective date of the dissolution of the domestic partnership or when the domestic partnership requirements are no longer met (submit the completed form *Termination of Domestic Partnership* [PS-425.4] to the Employee Benefits Division).

COBRA: Continuation of Coverage

Federal and State Laws

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows enrollees and their families to continue their health coverage in certain instances when coverage would otherwise end. In addition to the federal COBRA law, the New York State continuation coverage law, or “mini-COBRA,” extends the continuation period. Together, the federal COBRA law and NYS “mini-COBRA” provide 36 months of continuation coverage. Both laws are collectively referred to as “COBRA” throughout this book.

COBRA enrollees pay the full cost of coverage, plus a two percent administrative fee. There is no employer contribution to the cost of coverage. See “Costs under COBRA” later in this section.

Benefits under COBRA

COBRA benefits are the same benefits offered to retirees and dependents enrolled in NYSHIP. You must apply for COBRA coverage within 60 days from the date of loss of eligibility (see “Deadlines Apply,” page 70). Documentation of the COBRA-qualifying event may be required.

Eligibility

Enrollee

If you are a NYSHIP enrollee who is no longer covered through active employment, you have the right to COBRA coverage if the one-year coverage allowed/provided under Preferred List provisions is exhausted. (**Note:** You may be eligible to continue coverage as a retiree [see page 46] or vestee [see page 47].)

Dependents who are qualified beneficiaries

Dependents who are qualified beneficiaries have an independent right to up to 36 months of COBRA continuation coverage (from the time of your initial COBRA-qualifying event) and may elect Individual coverage. To be considered a qualified beneficiary, a dependent must:

- have been covered at the time of the enrollee’s initial COBRA-qualifying event or
- be a newborn or newly adopted child added to coverage within 30 days of birth or placement for adoption.

Spouse/domestic partner

The covered spouse or domestic partner of a NYSHIP enrollee has the right to COBRA as a qualified beneficiary if coverage under NYSHIP is lost as a result of:

- divorce
- termination of domestic partnership
- death of the enrollee
- the COBRA enrollee’s eligibility for Medicare*

Dependent children

The covered dependent child of a NYSHIP enrollee has the right to COBRA coverage as a qualified beneficiary if coverage under NYSHIP is lost as the result of:

- the child’s loss of eligibility as a dependent under NYSHIP (e.g. due to age)
- parents’ divorce or termination of domestic partnership
- death of the enrollee
- the COBRA enrollee’s eligibility for Medicare*

A COBRA enrollee's newborn child or a child placed for adoption with a COBRA enrollee is considered a qualified beneficiary if coverage for the child is requested within 30 days (see "Covering newborns," page 54, in *Coverage: Individual or Family* for enrollment rules).

**In no case will any period of continuation coverage last more than 36 months from the initial COBRA-qualifying event.*

Dependents who are not qualified beneficiaries

An eligible dependent may be added to COBRA coverage at any time in accordance with NYSHIP rules (see *Dependent Eligibility*, page 49, and *Coverage: Individual or Family*, page 53). However, a dependent added during a period of COBRA continuation coverage is not considered a qualified beneficiary (with the exception of a newborn or newly adopted child added within 30 days).

Dependents who are not qualified beneficiaries may only maintain coverage for the remainder of the enrollee's eligibility for COBRA continuation coverage.

Medicare and COBRA

When NYSHIP requires you or your enrolled dependent to enroll in Medicare, your NYSHIP COBRA coverage will be affected differently depending on which coverage you were enrolled in first. Read the section, "When You are Required to Have Medicare Parts A and B in Effect" in *Medicare and NYSHIP*, page 60, to learn when NYSHIP requires Medicare coverage to be in effect.

- If you are already covered under COBRA when you are required to enroll in Medicare, your NYSHIP COBRA coverage ends at the point when Medicare enrollment is effective. If you choose not to enroll in Medicare, your COBRA benefits will be drastically reduced (see "When You Are Required to Have Medicare Parts A and B in Effect" on page 60 of the section *Medicare and NYSHIP*). However, your eligible dependents who are considered qualified beneficiaries may continue their NYSHIP COBRA coverage for the remainder of the 36 months of COBRA continuation coverage (see "Continuation of Coverage Period" on page 71 of this section).
- If you are already covered under Medicare when you elect COBRA coverage, your Medicare coverage will pay first. When enrolled in COBRA coverage, Medicare is your primary coverage. If you do not enroll in Medicare when first eligible for Medicare-primary coverage, your NYSHIP coverage will be canceled or substantially reduced.

Choice of Option

An enrollee or dependent who continues coverage under COBRA will continue to be covered under the same option. COBRA enrollees may change to a different option once during a 12-month period (see *Your Options Under NYSHIP*, page 44) or when moving under the circumstances described in "Qualifying Events: Changing Options More Than Once During a 12-month Period" in *Your Options Under NYSHIP*, page 45. Dependents of a COBRA enrollee who are qualified beneficiaries may also change to Individual coverage once during a 12-month period.

Deadlines Apply

60-day deadline to elect COBRA

You must elect continuation coverage within **60 days** from the date of the COBRA-qualifying event.

Notification of dependent's loss of eligibility

To be eligible for COBRA coverage, the enrollee or covered dependent must notify the Employee Benefits Division within 60 days from the date of the COBRA-qualifying event. Examples of these events include:

- a divorce
- termination of a domestic partnership
- a child's loss of eligibility as a dependent under NYSHIP (see *Dependent Eligibility*, page 49)

Other people acting on your behalf may provide written notice of a COBRA-qualifying event to the Employee Benefits Division.

If the Employee Benefits Division does not receive notice in writing within that 60-day period, the dependent will not be entitled to choose continuation coverage.

Costs under COBRA

COBRA enrollees pay 100 percent of the premium for continuation coverage, and may be required to pay an additional two percent administrative fee. The Employee Benefits Division will bill you for the COBRA premiums.

45-day grace period to submit initial payment

COBRA enrollees will have an initial grace period of 45 days to pay the first premium starting from the date continuation coverage is elected. Since the 45-day grace period applies to all premiums due for periods of coverage prior to the date of the election, several months' premiums could be due and outstanding. The Employee Benefits Division will send bills monthly.

30-day grace period

After the initial 45-day grace period, enrollees will have a 30-day grace period from the premium due date to pay subsequent premiums.

Payment is considered made on the date of the payment's postmark.

Continuation of Coverage Period

You and your eligible dependents may have the opportunity to continue coverage under COBRA for up to 36 months.

If you lose COBRA eligibility prior to the end of the 36-month continuation coverage period, the duration of your dependents' coverage is as follows:

- **Dependents who are qualified beneficiaries:** COBRA continuation coverage may continue for the remainder of the 36 months.
- **Dependents who are not qualified beneficiaries:** COBRA continuation coverage will end when your coverage ends.

Survivors of COBRA enrollees

If you die while you are a COBRA enrollee in NYSHIP, your enrolled dependents who are qualified beneficiaries will be eligible to continue COBRA coverage for up to 36 months from the original date of COBRA coverage or may be eligible to convert to a direct-pay contract (see page 72).

When You No Longer Qualify for COBRA Coverage

Continuation coverage will end for the following reasons:

- the premium for your continuation coverage is not paid on time
- the continuation period of up to 36 months ends
- the enrollee or enrolled dependent enrolls in Medicare
- your employer no longer participates in NYSHIP

To Cancel COBRA

Notify the Employee Benefits Division if you want to voluntarily cancel your COBRA coverage (see "Model Letter for Contacting the Employee Benefits Division" on page 89 of the *Appendix*).

Conversion Rights after COBRA Coverage Ends

At the end of your COBRA continuation coverage period, you may be eligible to convert to a direct-pay conversion contract with the Empire Plan's Medical/Surgical Program administrator (see *Contact Information*, page 90).

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

If you were enrolled in an HMO, contact your HMO for more information.

Other Coverage Options

There may be other coverage options available to you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan).

Contact Information

If you have any questions about COBRA, please contact the Employee Benefits Division.

Direct-Pay Conversion Contracts

After NYSHIP coverage ends, or after eligibility for continuation coverage under COBRA ends, certain enrollees and their covered dependents are eligible for coverage through a direct-pay conversion contract. The benefits and the premium for direct-pay conversion contracts will be different from what you had under NYSHIP.

Eligibility

Empire Plan enrollees and/or covered dependents who lose eligibility for coverage for any of the following reasons may convert to a direct-pay contract:

- loss of eligibility for coverage as a dependent
- death of the enrollee (when the dependent is not eligible to continue coverage as a dependent, as outlined in *Dependent Survivor Coverage*, page 48)
- COBRA continuation eligibility ends, except when the loss of eligibility is the result of becoming Medicare-eligible due to age

A direct-pay conversion contract is not available to enrollees and/or covered dependents who:

- voluntarily cancel their coverage
- had coverage canceled for failure to pay the NYSHIP premium
- have existing coverage that would duplicate the conversion coverage
- are eligible for Medicare because of age

If you were enrolled in an HMO, contact that HMO for more information.

Deadlines Apply

You should receive written notice of any available conversion rights within 15 days after your coverage ends.

Your application for a direct-pay conversion policy and the first premium must be submitted within:

- 45 days from the date your coverage ends, if you receive the notice within 15 days after your coverage ends.
- 45 days from the date you receive the notice, if you receive written notice more than 15 days but less than 90 days after your coverage ends.
- 90 days from the date your coverage ends, if no notice of the right to convert is given.

No Notice for Certain Dependents

Written notice of conversion privileges will not be sent to dependents who lose their status as eligible dependents. For a direct-pay conversion contract, these dependents must apply within 45 days of the date coverage terminated.

How to Request Direct-Pay Conversion Contracts

To request a direct-pay conversion policy, write to the Empire Plan Medical/Surgical Program administrator (see *Contact Information*, page 90).

If you were enrolled in an HMO, contact that HMO for more information.

Young Adult Option

The Young Adult Option allows the child of a NYSHIP enrollee to purchase Individual health insurance coverage through NYSHIP when the young adult does not otherwise qualify as a dependent.

Eligibility

To enroll in NYSHIP under the Young Adult Option, the young adult must be:

- a child, adopted child, child of a domestic partner* or stepchild of a NYSHIP enrollee (including those enrolled under COBRA)
- age 29 or younger
- unmarried
- not eligible for coverage through the young adult's own employer-sponsored health plan, provided that the health plan includes both hospital and medical benefits
- living, working or residing in the insurer's service area
- not covered under Medicare

**Children of a domestic partner are only eligible to enroll in the Young Adult Option if the employer extends eligibility for NYSHIP coverage to domestic partners.*

Eligibility for NYSHIP enrollment under the Young Adult Option ends when one of the following occurs:

- The young adult's parent is no longer a NYSHIP enrollee.
- The young adult no longer meets the eligibility requirements for the Young Adult Option as outlined above.
- The NYSHIP premium for the young adult is not paid in full by the due date or within the 30-day grace period.

The young adult has no right to COBRA coverage when coverage under the Young Adult Option ends.

Cost

There is no employer contribution toward the cost of the Young Adult Option. The young adult or his or her parent is required to pay the full cost of the premium for Individual coverage.

Coverage

A young adult may enroll in any NYSHIP health plan for which the young adult is eligible. The young adult is not required to enroll in the same coverage option as the parent.

Enrollment Rules

Either the young adult or his or her parent may enroll the young adult in the Young Adult Option. Contact your employer for information about how to pay for this coverage.

A young adult can enroll in the Young Adult Option at one of the following times:

- **When NYSHIP coverage ends due to age**

If the young adult no longer qualifies as a parent's NYSHIP dependent due to age, he or she can enroll in the Young Adult Option within 60 days of the date eligibility is lost. Coverage is retroactive to the date that the young adult lost coverage due to age. This is the only circumstance in which the Young Adult Option will be effective on a retroactive basis.

- **When newly qualified due to a change in circumstances**

If the young adult has a change of circumstances that allows him or her to meet eligibility requirements for the Young Adult Option, he or she can enroll in the Young Adult Option within 60 days of newly qualifying. Examples of a change of circumstances include a young adult's loss of employer coverage or the young adult's divorce.

- **During the Young Adult Option Open Enrollment Period**

Coverage may be elected during the Young Adult Option annual 30-day open enrollment period. Contact the Employee Benefits Division for information about when this enrollment period will be and when your coverage will be effective.

When Young Adult Option Coverage Ends

Young Adult Option coverage ends on the last day of the month in which eligibility for coverage is lost or on the last day of the month in which voluntary cancellation is requested.

Questions

If you have any questions concerning eligibility, please contact the Employee Benefits Division.

Appendix

Empire Plan benefit card

Present this card whenever you or your covered dependents receive services or supplies. Medicare-primary enrollees and dependents may have a separate card for prescription drugs.

THE EMPIRE PLAN
NYSHIP

123456789

JEANNIE EMPIRE PLAN ENROLLEE
JANE EMPIRE PLAN ENROLLEE
JOHN EMPIRE PLAN ENROLLEE
MICHAEL EMPIRE PLAN ENROLLEE
JAMES EMPIRE PLAN ENROLLEE
MARY EMPIRE PLAN ENROLLEE

 New York State Health Insurance Program

For enrollee services, precertification & provider relations, please call:

**1-877-7-NYSHIP
(1-877-769-7447)**

Providers: This card represents but does not guarantee enrollment in the New York State Health Insurance Program (NYSHIP) for Government Employees.
Submit hospital, skilled nursing facility and hospice claims to your local Blue Cross and/or Blue Shield Plan. Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.


 **Blue Cross Prefix: YLS**

Submit medical provider claims in accordance with your participating provider agreement.
UnitedHealthcare  MultiPlan

All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.
Administered by the New York State Department of Civil Service.


Empire Plan Medicare Rx card

Medicare-primary Empire Plan enrollees and dependents use this card to fill prescriptions.

SILVERSCRIPT 

**Prescription Drug Plan Administered by
CVS Caremark Part D Services, LLC**

RXBIN: XXXXXX
RXPCN: XXXXXX
RXGRP: XXXXXX
ISSUER (80840): 9151014609
ID: XXXXXXXXXXXX
NAME: JOHN Q PUBLIC

 MedicareRx
Prescription Drug Coverage

S5601 811

Submit Medicare Part D Paper Claims to:
Claims Form Processing
P.O. Box 52066
Phoenix, AZ 85072-2066

Empire Plan Medicare Rx Customer Care:
1-877-769-7447 and select option 4
24 hours a day, 7 days a week
TTY: 1-866-236-1069

Pharmacy Help Desk For Providers:
1-866-693-4620

EmpirePlanRxProgram.com

 New York State Health Insurance Program

Claims administered by CVS Caremark Part D Services, LLC.

Health Insurance Transaction Form (PS-404)

Active enrollees, submit this form to your Health Benefits Administrator to make any enrollment changes.

	Department of Civil Service	EMPLOYEE BENEFITS DIVISION NYS HEALTH INSURANCE TRANSACTION FORM	PS-404 (9/15)
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INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION <i>(All employees must complete)</i>									
1. Last Name			First Name		MI	2. Social Security Number		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Street Address				City		State		Zip	
5. Date of Birth		6. Telephone Numbers Primary () Work ()				7. Work location and address			
8. Marital Status		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		Marital Status Date			
<input type="checkbox"/> Single		<input type="checkbox"/> Widowed		<input type="checkbox"/> Separated					
9. Covered under Medicare? Self:			<input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse/Domestic Partner:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
					Child:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. DEPENDENT INFORMATION									
Must be provided when choosing to enroll or opt-out of NYSHIP family coverage <i>(use additional sheets if necessary)</i>									
Check One: A (Add), D (Delete) or C (Change)									
Check all that apply: M (Medical), D (Dental), and V (Vision)									
Date of Event _____									
↓	↓	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address (if different)	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
11. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A, B OR C)									
A. Enroll in NYSHIP Coverage: Choose options 1 or 2 and complete box 3									
1. Individual Enrollment		Medical (10) <i>(Select Empire Plan or HMO)</i>				<input type="checkbox"/> Dental (11)		<input type="checkbox"/> Vision (14)	
		<input type="checkbox"/> Empire Plan		<input type="checkbox"/> HMO Code _____ Name _____					
2. Family Enrollment		Medical (10) <i>(Select Empire Plan or HMO)</i>				<input type="checkbox"/> Dental (11)		<input type="checkbox"/> Vision (14)	
<i>(Complete box 10)</i>		<input type="checkbox"/> Empire Plan		<input type="checkbox"/> HMO Code _____ Name _____					
3. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction			<input type="checkbox"/> Elect Post-Tax Status for Premium deduction						
Please read the Pre-Tax Contribution program materials.									
B. Elect the Opt-out program (if eligible): Complete boxes 1 and 2									
1. <input type="checkbox"/> Individual Opt-out		<input type="checkbox"/> Family Opt-out		If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.					
2. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction		<input type="checkbox"/> Elect Post-Tax Status for Premium deduction							
Please read the Pre-Tax Contribution program materials.									
C. Decline NYSHIP Coverage									
			<input type="checkbox"/> Medical (10)		<input type="checkbox"/> Dental (11)		<input type="checkbox"/> Vision (14)		
12. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW									
A. Change Coverage:		<input type="checkbox"/> Medical (10)		<input type="checkbox"/> Dental (11)		<input type="checkbox"/> Vision (14)		Date of Event: _____	
<input type="checkbox"/> Change to FAMILY <i>(Complete box 10)</i>				<input type="checkbox"/> Change to INDIVIDUAL					
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce				<input type="checkbox"/> Termination of Domestic Partnership <i>(Attach completed PS-425.4)</i>			
<input type="checkbox"/> Domestic Partner		<input type="checkbox"/> Only dependent ineligible due to age				<input type="checkbox"/> I voluntarily cancel coverage for my dependents			
<input type="checkbox"/> Newborn		<input type="checkbox"/> Only dependent died				<input type="checkbox"/> Only dependent married <i>(Dental and Vision only)</i>			
<input type="checkbox"/> Request coverage for dependents not previously covered		<input type="checkbox"/> Only dependent graduated <i>(Dental and Vision only)</i>				<input type="checkbox"/> Other _____			
<input type="checkbox"/> Previous coverage terminated <i>(proof required)</i>									
<input type="checkbox"/> Dependent returned to full-time student status <i>(Dental and Vision only)</i>									
<input type="checkbox"/> Other _____									
B. Voluntarily Cancel Coverage:		<input type="checkbox"/> Medical (10)		<input type="checkbox"/> Dental (11)		<input type="checkbox"/> Vision (14)		Qualifying Event:	
NOTE: If you are enrolled in the Pre-Tax Contribution Program, your ability to make mid-year changes may be limited.									

13. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW							
Change NYSHIP Option		Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/> HMO Name _____					
Elect Opt-out (if eligible)		<input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.					
Change Pre-Tax Status		Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax Submit during the Pre-Tax Contribution Selection Period (November 1-30)					
14. LEAVE WITHOUT PAY AND RETIREMENT STATUS							
LEAVE WITHOUT PAY		<input type="checkbox"/> I wish to continue coverage while I am on authorized leave. I understand that I will be billed and must pay for this coverage.		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
		<input type="checkbox"/> I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
RETIREMENT		<input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.					
		<input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. <i>(A completed PS-406.2 must be attached.)</i>					
		<input type="checkbox"/> I understand that I will receive an application for COBRA continuation of Dental and/or Vision coverage automatically.					
Personal Privacy Protection Law Notification							
The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, contact your Health Benefits Administrator . If, after calling your Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.							
AUTHORIZATION							
I have read the Pre-Tax Contribution Program materials and the Opt-out Attestation Form (if applicable), and have made my selection on Page 1 of this document. I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current <i>Summary of Benefits and Coverage</i> for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.							
Employee Signature (Required):						Date:	
AGENCY/EBD USE ONLY							
Action/Reason	Date of Event	Hire Date	Date of 1 st Eligibility	Percentage Working	Agency Code	Neg. Unit	Retirement System
Retirement Tier	Registration #	Sick Leave Information # Hours Hourly Rate of Pay		Date Entered on NYBEAS	Effective Date		
HBA Signature (Required):						Date:	

Retirement Check

If your NYSHIP premium is deducted from monthly NYSLERS retirement checks mailed to your home, your retirement check will reflect the amount deducted for health insurance coverage and any Medicare credits.



NEW YORK STATE & LOCAL RETIREMENT SYSTEMS

Name:
Retirement #:

Check #
Date: April 30, 2015
Registration #:

NORMAL ALLOWANCE	C. O. L. A/ SUPPLEMENTAL	MEDICARE CREDIT			GROSS TOTAL
\$2,955.53	\$15.00	\$104.90			\$3,075.43
FEDERAL WITHHOLDING	INSURANCE PREMIUM				TOTAL DEDUCTIONS
	\$372.25				\$372.25
					CHECK AMOUNT
					\$2,703.18

IN THE EVENT OF THE DEATH OF THE PAYEE, THIS CHECK IS VOID AND MUST BE RETURNED TO THE PAYER.

If you have questions, need to order forms and booklets, or change your mailing address, please contact our Call Center toll-free at 1-866-805-0990, or 518-474-7736 in the Albany, New York area.

You may also call this number to request a direct deposit enrollment form. With direct deposit, funds are deposited directly into your account, replacing the traditional "check in the mail." Direct deposit is the most reliable, easiest and safest way to get your monthly pension payment with no hassles.

DETACH HERE BEFORE CASHING

Notice of Change Document

If your NYSHIP premium is deducted from your NYSLERS pension, and you receive your pension by direct deposit, you will receive this document annually when premium rates change. You will also receive this document at any time there is a change to the credits or deductions listed on the document.

NOTICE OF CHANGE IN YOUR NET RETIREMENT BENEFIT DEPOSITED FOR MONTH ENDING January 30, 2015.

Registration #: YTD Federal Tax Withheld: \$0.00
 Retirement #:

The credits and deductions which make up your net retirement benefits are shown below for the last month and this month. Items which will change this month are indicated by an *.

	<u>Last Month</u>		<u>This Month</u>
A → <u>Benefits</u>			
Normal Allowance	\$2,955.53		\$2,955.53
Cost of Living	\$15.00		\$15.00
Supplemental Allowance	\$0.00		\$0.00
Benefit Adjustments	\$14.50	*	\$0.00
Gross Benefit	\$2,985.03	*	\$2,970.53
 <u>Miscellaneous Adjustments</u>			
Total Federal Withholding Tax	\$0.00		\$0.00
Miscellaneous Deductions	\$0.00		\$0.00
 <u>Health Insurance</u>			
B → Health Ins. Deduction	\$364.47		\$372.25
C → Medicare Credit	\$104.90		\$104.90
D → Medicare Deduction	\$0.00		\$0.00
Net Retirement Benefit Paid	\$2,725.46	*	\$2,703.18

This difference is due to changes in your basic benefits. You should have already been advised regarding this matter.

I hope this information is helpful to you. If you have any questions, need to order forms and booklets, or change your mailing address, please contact our Call Center toll-free at (866) 805-0990, or (518) 474-7736 in the Albany area.

- A** “Benefits” refers to your pension benefits, not your health insurance benefits.
- B** Your “Health Insurance Deduction” is the monthly amount you are responsible for paying, after any sick leave credit you may have is applied to the monthly premium for the option and coverage you have selected. The *Health Insurance Choices and Rates* packet, mailed to you each fall, includes the amount of your sick leave credit (if applicable).
- C** “Medicare credit” shows your monthly reimbursement for the standard Medicare Part B premium, if applicable.
- D** For most retirees, the Medicare premium is withheld from their Social Security check. This line only applies to retirees who do not have their Medicare premium withheld from their Social Security check.

Bill from the Employee Benefits Division

If you receive a monthly bill directly from the Employee Benefits Division for NYSHIP coverage, your bill will show the cost of your NYSHIP coverage, the period you are being billed for, the plan you are enrolled in and the type of coverage you are enrolled in (Individual or Family).

0000115451R011000724598X

STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
EMPLOYEE BENEFITS DIVISION
PO BOX 3799
NEW YORK, NY 10008-3799

Make your check or money order payable to:
NYS Employee Insurance Pending Account

DO NOT SEND CASH

PAYMENT DOES NOT ESTABLISH ELIGIBILITY FOR BENEFITS;
PAYOR MUST SATISFY ELIGIBILITY REQUIREMENTS

ENROLLEE, JANE
12 MAIN ST
ANYTOWN, NY 11111

Benefit Program	ROI
Due Date	07/31/2015
Amount Due	\$ 1,154.51
Amount Paid	<input type="text"/>

DETACH HERE AND RETURN THIS PART WITH YOUR PAYMENT

--RETAIN THIS PART FOR YOUR RECORDS--

NEW YORK STATE DEPT. OF CIVIL SERVICE
EMPLOYEE BENEFITS DIVISION
EMPIRE STATE PLAZA CORE BUILDING 1, 2ND FLOOR
ALBANY, NY 12239
Outside Continental US/ALBANY 518-457-5754
Continental US 1-800-833-4344

Page 1 of 1

BILLING STATEMENT AS OF 07/03/2015
FOR PERIOD ENDING 08/31/2015
DUE DATE 07/31/2015

Name: ENROLLEE, JANE

Benefit Program: ROI

Date	Activity Type	Benefit Type	Plan Type	Benefit Plan	Coverage	Units	Amount	
Beginning Balance							\$ 83.77	
A → 06/01/15	CHRG	Prior Period	Retiree	Medical	EMPIRE	Family	2	744.50
B → 06/01/15	SKLV	Prior Period		Medical	EMPIRE	Family	2	86.52CR
08/01/15	ADMN		Retiree	Dental	PREFERRED	Family	1	1.46
08/01/15	ADMN		Retiree	Vision	DAVIS	Family	1	0.19
C → 08/01/15	CHRG		Retiree	Medical	EMPIRE	Family	1	372.25
08/01/15	CHRG		Retiree	Dental	PREFERRED	Family	1	72.78
08/01/15	CHRG		Retiree	Vision	DAVIS	Family	1	9.34
D → 08/01/15	SKLV			Medical	EMPIRE	Family	1	43.26CR
TOTAL DUE FOR PERIOD ENDING 08/31/2015							\$ 1,154.51	

A Charges accrued prior to this billing cycle (in this example, for June and July coverage)

B Sick leave credit accrued from prior billing cycle

C Charge for current coverage

D Sick leave credit for current coverage

NYSHIP Option Transfer Request

Retirees, submit this form to the Employee Benefits Division to request a change from one NYSHIP option to another.

Enrollee Name _____

Social Security Number (SSN) _____

Mailing Address _____

County _____ City or Post Office _____

State _____ ZIP Code _____ Telephone Number (_____) _____

Is this a new address? Yes No Date of New Address _____

Residential Street Address (if different) _____

County _____ City or Post Office _____

State _____ ZIP Code _____

Medicare Yes No If Yes, Effective Dates: Part A _____ Part B _____

Dependent Medicare Yes No If Yes, Effective Dates: Part A _____ Part B _____

Are you or your dependent reimbursed from another source for Part B coverage? Yes No

If Yes, by whom? _____ Amount \$ _____

Effective _____ 1, 20_____, please change my health insurance option
(month) (year)

From: Current Option Code Number _____ Current Plan Name _____

To: New Option Code Number _____ New Plan Name _____

Date _____ Enrollee Signature (*required*) _____

If you have Family coverage, please complete the following for each dependent enrolled in Medicare (*attach a separate sheet of paper if necessary*):

Dependent Name _____ SSN _____

Medicare ID # (*on his or her Medicare card*) _____ Date _____

Dependent Signature (*required*) _____

Dependent Name _____ SSN _____

Medicare ID # (*on his or her Medicare card*) _____ Date _____

Dependent Signature (*required*) _____

I have no Medicare-eligible dependents

If you are enrolling in an HMO, is the HMO approved by NYSHIP to serve your county?

Please check the *NYSHIP Options by County* guide.

No action is required if you wish to keep your current health insurance.

USE THIS FORM FOR OPTION CHANGE ONLY

Dear Retiree Letter

At the time of retirement, the Employee Benefits Division sends this letter explaining the current cost of coverage, the amount of your sick leave credit and the method by which you will pay the NYSHIP premium as a retiree. Keep this letter for future reference.



**Department of
Civil Service**

EMPLOYEE BENEFITS DIVISION

ANDREW M. CUOMO
Governor

June 26, 2015

Mrs. Jane Enrollee
12 Main St.
Anytown, NY 11111

Retirement Registration #: 9999999
Retirement #: OS9999999

Dear Mrs. Jane Enrollee

This letter confirms that you are enrolled in the **New York State Health Insurance Program (NYSHIP) as a Retiree with The Empire Plan Family coverage.** Your effective date of retiree coverage is May 29, 2014.

What You Pay Monthly for Your NYSHIP Coverage

Your current monthly premium for this coverage is \$312.27, which will be reduced by your monthly sick leave credit of \$5.18. You have selected the Single Annuitant sick leave option. If your sick leave credit is more than your monthly premium, you will NOT receive a credit for the difference. For additional sick leave information please refer to the NYSHIP General Information booklet.

How to Pay Your NYSHIP Premium

Prior to the finalization of your retirement pension calculation by your retirement system:

If the Retirement Number above is blank and you owe health insurance premiums, you will be billed monthly until your retirement system provides us with your retirement number. Your initial bill will include all premiums due from the effective date of your retiree coverage through the current coverage period. You will continue to receive monthly billing statements until your retirement pension calculation is finalized. NOTE: The New York State administered retirement systems will not deduct health insurance premiums from estimated pension checks.

If payment is not received timely, you may be cancelled for non-payment, which could result in health insurance claims problems and/or denial of services.

After your retirement pension is finalized or if your retirement number is indicated above:

The Employee Benefits Division (EBD) will automatically begin the pension deduction process once your information is received. The initial deduction may include retroactive premiums due. If that is the case, deductions will be taken in maximum increments of \$750 per month until such retroactive premiums are paid in full.

Medicare and NYSHIP

When Medicare first becomes primary you and your Medicare eligible dependent(s) must be enrolled in Medicare Part A and Part B. Failure to enroll will affect your NYSHIP benefits.

If you and/or your dependent(s) are eligible for coverage under Medicare, we will automatically reimburse you for the standard Medicare Part B premium, unless you are receiving Medicare reimbursement from another source, such as a former employer of you or your spouse. You must notify us of other reimbursement immediately as reimbursement from multiple sources is not allowed and you will be responsible for repaying any duplicate reimbursements.

How You Will Receive Medicare Part B Reimbursement

Prior to the finalization of your retirement pension:

The reimbursement for the Medicare Part B standard premium for you and any Medicare eligible dependents will be applied to reduce your monthly premium payments. If your Medicare credit exceeds your health insurance premium, you will automatically receive the difference via a quarterly refund check issued by the Office of the State Comptroller.

After your retirement pension is finalized:

Medicare Part B reimbursement is credited to your pension check on a monthly basis. If the initial credit exceeds \$500.00, you will receive the maximum credit of \$500 in your pension check and any remaining credit will be received via a refund check issued by the Office of the State Comptroller. The following month's pension allowance will reflect your regular monthly Medicare Part B premium credit.

If you have questions or require additional information, please visit our website at www.cs.ny.gov, write to us at the above address or call the Retiree Unit at 518-457-5754 in the Albany area, or toll free at 1-800-833-4344. Representatives are available between the hours of 9:00 a.m. and 3:00 p.m. EST, Monday through Friday.

Sincerely,

Retiree Unit, Program Administration
Employee Benefits Division

NYSHIP Medicare Advantage HMO Disenrollment Form

If you are enrolled in a NYSHIP HMO Medicare Advantage plan, submit this form to the Employee Benefits Division along with the NYSHIP Option Transfer Request form to request a change from one option to another.

Effective _____, **please cancel my enrollment in:**
Enter date here (must be the first of a month)

Option Code Number _____ Plan Name _____

Social Security Number _____

Member's Name _____
First Middle Last

Address _____

Telephone Number (_____) _____

Medicare Number (As it appears on your Medicare Card) _____

Date _____ Enrollee's Signature _____

Please provide the following required information for each enrolled dependent.

(Attach an additional 8½" x 11" sheet of paper, if necessary).

Dependent's Name _____

Dependent's Social Security Number _____

Dependent's Medicare Number (if applicable) _____

Dependent's Signature _____

Dependent's Name _____

Dependent's Social Security Number _____

Dependent's Medicare Number (if applicable) _____

Dependent's Signature _____

Important: Complete and mail this form to the HMO you are leaving as early as possible prior to the effective date you are requesting. Termination of coverage with this HMO must be coordinated with your new option. You will not be able to receive coverage for medical care from your new option until after the effective date of disenrollment.

No action is required if you wish to keep your current health insurance.

USE THIS FORM FOR OPTION CHANGE ONLY

IRMAA Letter

The IRMAA Letter explains how to receive reimbursement for the Medicare Part B IRMAA. All enrollees and dependents age 65 and over are sent this letter annually.



Department of Civil Service

January 2016

Reimbursement of the 2015 Medicare Part B Income-Related Monthly Adjustment Amount (IRMAA)

STOP!

DISREGARD this mailing if you and your dependent paid ONLY the standard 2015 Medicare Part B premium of \$104.90 per month.

This letter includes information for New York State Health Insurance Plan (NYSHIP) enrollees and their covered dependents who are Medicare primary and pay a Medicare Part B Income-Related Monthly Adjustment Amount (IRMAA) that is higher than the standard Medicare Part B premium. NYSHIP automatically reimburses the standard Medicare Part B premium on a monthly or quarterly basis, but you must request reimbursement for any IRMAA premium paid by completing the enclosed form and providing acceptable proofs of payment.

The following questions and answers explain who is eligible and, if so, how to apply for reimbursement.

Q: How do I know if I am eligible for this additional reimbursement of Medicare Part B premium?

A: The information in this letter applies ONLY to individuals covered under NYSHIP who paid 2015 Medicare Part B premiums that were more than the standard premium of \$104.90 per month due to their 2013 income level. IRMAA for 2015 is assessed by Medicare to individual income tax filers with Modified Adjusted Gross Income (MAGI) of more than \$85,000 per year and married income tax filers with MAGI of more than \$170,000 per year. If you did not pay IRMAA for Medicare Part B coverage, you are NOT eligible for IRMAA premium reimbursement and the information below does not apply to you.

If you and/or any of your Medicare primary enrolled dependents were subject to a higher Medicare Part B premium due to IRMAA in 2015, you probably received a letter in November 2014 from the Social Security Administration (SSA) advising you of the IRMAA you were required to pay. If you were new to Medicare in 2015, the SSA letter would have been sent to you prior to your first month of Medicare eligibility. Whether the higher amount was deducted from your monthly Social Security benefit check or you paid it directly to Medicare, you are eligible to be reimbursed by NYSHIP for any additional IRMAA premium paid for 2015 over the standard Medicare Part B premium of \$104.90, provided you do not receive Medicare reimbursement from another source.

Q: How do I apply for the reimbursement of 2015 Medicare Part B IRMAA for myself and/or my dependent(s) covered under NYSHIP?

A: To receive IRMAA reimbursement, you must provide:

1. A completed, signed application (see attached), and
2. A copy of the SSA notice you and/or any of your Medicare-primary enrolled dependents received dated November 2014 (or during 2015 if newly eligible for Medicare) that states your 2015 monthly Medicare premium includes IRMAA, and
3. Proof of payment of the Medicare premium. Acceptable proof of payment is a copy of the 2015 form SSA-1099 that you and/or your Medicare primary enrolled dependent received from SSA or proof of direct payments and billing statements for all premiums paid directly to the Centers for Medicare and Medicaid Services (CMS) in 2015.

Q: I cannot locate my 2015 SSA notice regarding IRMAA. How do I get a copy?

A: If you need a replacement copy of your 2015 SSA notice, request one from your local Social Security office or online at www.socialsecurity.gov/onlineservices. The location of your local office can be found in your telephone directory or on the Social Security web site address provided in this answer.

Q: Is there a deadline for applying for 2015 IRMAA reimbursement?

A: All requests for reimbursement must be submitted within three years of the tax filing year. For example, the filing date for 2012 Income Tax was April 15, 2013. Therefore, you may request IRMAA reimbursement for 2012 until April 15, 2016.

Q: How and when will I receive my reimbursement?

A: All reimbursements for IRMAA are issued as a refund check from the New York State Office of the State Comptroller. All IRMAA reimbursement checks, including those reimbursements for eligible dependents, are issued in the name of the NYSHIP enrollee, to the mailing address of record on your enrollment file. Due to the volume of requests for IRMAA reimbursement, you can expect the process to be complete within 90 - 120 days from receipt and acceptance of all required IRMAA documents.

Q: My dependent receives Medicare Part B reimbursement from his/her former employer. How does this affect my reimbursement from NYSHIP?

A: You are not entitled to any amount that is reimbursed from another source. If you and/or your dependent receive Medicare reimbursement from another source, please contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (9 am - 4 pm Eastern time) for additional instructions or provide that information with your application materials.

Q: Can I be reimbursed for my Medicare Part D (drug coverage) IRMAA payments?


A: No, the Department has no legal authority to reimburse the Medicare Part D portion of the IRMAA assessment.

Q: I filed an appeal for reconsideration of my IRMAA rate. What do I need to do?

A: If your IRMAA rate for the current or prior year is adjusted by Medicare, you must submit all correspondence regarding the adjustment to the Employee Benefits Division

Change of Address Form

(For Participating Employer Retirees) If your address changes, you must complete this form and submit it to the Employee Benefits Division.

 <p>NEW YORK STATE OF OPPORTUNITY.</p>	<p>Department of Civil Service</p>	<p>EMPLOYEE BENEFITS DIVISION Change of Address</p>	PS-850 (4/16)
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As you know, your Health Insurance information is important.

You may not receive information regarding your benefits if your address is not kept current on the New York State Health Insurance Program (NYSHIP) enrollment records.

Note: Your enrollment record cannot be updated without your signature.

Please complete the information below and return it to the following address.

**NYS Department of Civil Service
Employee Benefits Division
Program Administration Unit
Empire State Plaza, Core Building 1
Albany, NY 12239**

If you have any questions, you may contact the Employee Benefits Division at 1-800-833-4344.

Health Insurance Identification No.					
Last Name		First Name			Middle Initial
Old Address:			New Address:		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Telephone Number (Include Area Code) ()			Effective Date of Change		
Signature (Required):				Date:	

(If Power of Attorney – Please send copy)

<p>Power of Attorney/Guardianship – If you are acting on behalf of an enrollee, your “documents” must be on file with our office before any benefit changes, including mailing address, can be processed.</p> <p style="text-align: center;"> <input type="checkbox"/> ENCLOSED <input type="checkbox"/> ALREADY ON FILE WITH EBD </p>
--

Personal Privacy Protection Law Notification – The information you provide on this application is being requested in accordance with Article 11 of the Civil Service Law for the principal purpose of enabling the Department of Civil Service to process a request to change the address listed on your New York State Health Insurance Program enrollment record. The information will be used in accordance with section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by your personnel office, and by the Employee Benefits Division, Department of Civil Service, Albany, New York 12239. For information concerning *only* the Personal Privacy Protection Law, call (518) 457-9375. For information relating to this form, please call 1-(800) 833-4344.

FOR OFFICE USE ONLY		
	DATE	INITIALS

Disability Award Letter

If you are awarded a disability retirement, the effective date of your retirement is listed in this letter. You must send a copy to the Employee Benefits Division.



Office of the New York State Comptroller
Thomas P. DiNapoli

New York State and Local Retirement System
Employee's Retirement System
Police and Fire Retirement System

110 State Street, Albany, New York 12244-0001
Phone: 1-866-805-0990 or 518-474-7736 Fax: 518-402-4433
Email: nyslrinfo@osc.state.ny.us Web: www.osc.ny.us/retire

John Q. Enrollee
1 Main Street
Anytown, NY 11111

March 26, 2015
In reply refer to
Reg. No.: 00000000
S.S. No.:XXXXX0000
Unit ID: Dsblty Calc
User ID: XX000

Dear Mr. Enrollee:

The effective date of your Article 15 Accidental disability benefit has been established as January 14, 2013.

We will be sending you an estimate of the amounts payable under the various options as soon as possible. At that time, you will be given the opportunity of changing your present option selection if you want to.

You selected the Single Life Allowance (Option 0). Under this option all payments will stop at your death.

Your date of birth has been verified as April 9, 1975.

The Retirement System does not administer health insurance programs. Prior to your retirement date, you should direct any health insurance questions you may have to your personnel office. After retirement, New York State employees should contact the NYS Department of Civil Service, Health Insurance Section, Alfred E. Smith State Office Building, Albany, NY 12239. All non-state employees, such as city, town, village or school district employees, should direct their health insurance questions to the personnel office of their former employers.

If you have a loan balance on the effective date of your retirement, part or all of the unpaid loan balance may constitute interest credited to your member contributions and therefore, be subject to Federal Income Tax for the year you retire.

Your first full retirement benefit payment will be retroactive to your date of retirement. In the meantime, while we are calculating your final retirement benefit, you may receive advance payments. These advance payments, which are partial amounts of what your final benefit will be, will be paid monthly in the form of a paper check and mailed to the address we have on file for you.

Retirement payments may be subject to Federal income tax withholding. According to Internal Revenue Service guidelines, we must base your Federal withholding on a status of married with three exemptions, unless you complete and return the enclosed W-4P form. Please review the tax-related information at the end of this letter.

Model Letter for Contacting the Employee Benefits Division

If you need to write to the Employee Benefits Division, be sure to include all of the information requested in this model letter.

Mail to: NYS Department of Civil Service
Employee Benefits Division
Program Administration Unit
Empire State Plaza, Core Building 1
Albany, NY 12239

(Please print)

Last four digits of Social Security number XXX-XX- _____

Name of Enrollee _____

Street _____

City _____ State _____ Zip _____

This is a new address. Please complete Form PS-850.

Telephone: Day _____ (area code) _____ Night _____ (area code) _____

I am writing because:

Effective date requested for change _____

Signature _____ Date _____

Name (please print) _____

Dependent Name* _____

Last four digits of Social Security number XXX-XX- _____

Medicare ID number (from Medicare card) _____ Date _____

Dependent Signature (required if Medicare primary) _____ Date _____

I am enclosing a photocopy of my (or my dependent's) required documentation, including Medicare card (if applicable).

I have no Medicare-eligible dependents.

* Attach an additional sheet if necessary.

Contact Information

Health Benefits Administrator (fill in)

Name: _____ Phone Number: _____

Email: _____

Employee Benefits Division

518-457-5754 or 1-800-833-4344

Representatives are available Monday through Friday, 9 a.m. to 4 p.m. Eastern time

New York State Department of Civil Service

Employee Benefits Division

Albany, New York 12239

Empire Plan

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

PRESS ORSAY 1 Medical/Surgical Program *Administered by UnitedHealthcare*

Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time.

TTY: 1-888-697-9054

P.O. Box 1600

Kingston, NY 12402-1600

PRESS ORSAY 2 Hospital Program *Administered by Empire BlueCross BlueShield*

Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

TTY: 1-800-241-6894

New York State Service Center

P.O. Box 1407

Church Street Station

New York, NY 10008-1407

PRESS ORSAY 3 Mental Health and Substance Abuse Program *Administered by Beacon Health Options*

Representatives are available 24 hours a day, seven days a week.

TTY: 1-855-643-1476

P.O. Box 1800

Latham, NY 12110

PRESS ORSAY 4 Prescription Drug Program *Administered by CVS/caremark*

Representatives are available 24 hours a day, seven days a week.

TTY: 1-800-863-5488

Customer Care Correspondence

P.O. Box 6590

Lee's Summit, MO 64064-6590

NYSHIP HMOs

NYSHIP HMO contact information, including phone numbers, TTY numbers, addresses and web sites are available in the *Choices* booklet and on the Department of Civil Service web site at www.cs.ny.gov.

Other Agencies and Programs

New York State and Local Employees' Retirement System	518-474-7736
TIAA/CREF.....	518-786-5900
New York State and Local Police and Fire Retirement System.....	518-474-7736
Medicare – Social Security Administration.....	1-800-MEDICARE (1-800-633-4227)

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Notes

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

Important Health Insurance Information:

General Information Book for Employees, Retirees, Vestees and Dependent Survivors enrolled in NYSHIP through Participating Employers, their enrolled Dependents, Preferred List and COBRA enrollees and Young Adult Option enrollees with their Empire Plan benefits

PE Active and Retiree/General Information Book – 2016

Change Service Requested

Please do not send mail or correspondence to the return address above. See address information on page 90.

**SAVE
– THIS –
BOOK**

**Important information about the
New York State Health Insurance Program**

This book replaces your previous *NYSHIP General Information Book (GIB)* and all amendments updating that book.

Updates to this book will be mailed to you and will also be posted on our web site, www.cs.ny.gov.
Keep all updates with this book.



NYSHIP
New York State
Health Insurance Program

Reasonable accommodation: It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. If you need an auxiliary aid or service to make benefits information available to you, please contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).