General Information Book

** This section does not apply to Excelsior Plan enrollees. Excelsior Plan prescription drug benefits are not affected by Medicare eligibility.*

Introduction

This is the *New York State Health Insurance Program (NYSHIP) General Information Book* for individuals enrolled in NYSHIP through a local government agency that elects to participate in NYSHIP (Participating Agency) and their covered dependents. It includes information about NYSHIP requirements and the NYSHIP rules that your employer must follow. For specific information that applies to you, speak to your Health Benefits Administrator. 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 agency to be eligible for retiree coverage (if you are eligible) and when your benefits go into effect. This is not an inclusive list.

About This Book

This book explains certain rights and responsibilities you have as an enrollee in the New York State Health Insurance Program (NYSHIP). Receipt of this book does not guarantee you are eligible or enrolled for coverage. See your Health Benefits Administrator for eligibility and enrollment information.

This book has two sections. The first section, beginning on page 3, applies to active employees. The second section, beginning on page 34, 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 or dependent survivors or covered as a dependent of an enrollee who is no longer an active employee. Be sure you refer to the appropriate section of the book for information.

The New York State Health Insurance Program (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 and extended administratively to Participating Agencies. NYSHIP provisions negotiated with State employee unions may be administratively extended to Participating Agencies. 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 record. Please make sure that your Health Benefits Administrator has your most current address. Amendments and notification of changes also can be found on the Department's web site, www.cs.ny.gov.

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.

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 of the following situations:

Your mailing address or your home address changes (If you are Medicare primary, or a covered dependent is Medicare primary and your mailing address is a P.O. Box, your Health Benefits Administrator needs 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 5 [active] or page 38 [retiree] for details)

- You want to add or remove a covered dependent or change your type of coverage (Individual/Family)
- Your covered dependent loses eligibility
- You get divorced
- You or a dependent dies (submit a copy of the death certificate to your Health Benefits Administrator)

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 Agency 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 29 [active] or page 46 [retiree])
- 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 COBRA (see *COBRA: Continuation of Coverage,* page 20 [active] or page 56 [retiree])

Questions About Your Benefits

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. See *Contact Information,* page 68, for details.

Benefits on the web

You'll find NYSHIP Online, the NYSHIP homepage, on the New York State Department of Civil Service web site at https://www.cs.ny.gov. Click on Benefit Programs, then NYSHIP Online. Copies of NYSHIP documents and informational materials are available on NYSHIP Online. There are also links to Plan administrator web sites, which include the most current lists of network providers.

General Information Book

For Active Employees of Participating Agencies

Refer to this portion of the book for information if you are still actively employed by a NYSHIP Participating Agency, 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 Agency, refer to the second part of this book, pages 34-62, for information.

Employee Eligibility

Minimum eligibility requirements for coverage are established by New York State law. Participating Agency 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 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 11).

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 for at least three months.

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***

   you meet one of the following criteria:

   - are a local elected official,
   - are a paid member of a public legislative body,
   - are an elected member of a school board,
   - are an unpaid board member of a public authority with at least six months' service as a board member,
   - are a volunteer firefighter or ambulance worker, ***or***
   - the major source of your family's income comes from your public employment.

3. You are not already enrolled in NYSHIP as an employee.

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.
- 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, an agency may offer NYSHIP coverage to teachers, but not to teachers' aides.) Eligibility may be established through collective bargaining agreements or administratively by your employer.
- Your employer may provide The Empire Plan to certain classes or categories of employees and Excelsior Plan to other classes or categories of employees. No class or category of employee may be offered both.

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 his local library, a NYSHIP Participating Agency. Bob is eligible to be enrolled in NYSHIP as a retiree of New York State or as an employee through the library. 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 9).

Example: Both Bob and his spouse are eligible for NYSHIP as the result of their active employment. Bob may be covered by his employer as the enrollee and also as his spouse's NYSHIP dependent.

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. See page 9 for information regarding when coverage will be effective.

If your dependent is eligible for NYSHIP but not enrolled, contact your Health Benefits Administrator to enroll in coverage.

See *Proof of Eligibility* on page 7 for required proofs that must be submitted with the request to add a dependent to your coverage.

For more information about waiting periods when enrolling a dependent, see *When Your Dependent's Coverage Begins,* page 9.

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 32 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

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, page 8. ***Rules for domestic partners or children of domestic partners in this book apply only if that coverage is offered by your employer.*** *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 decree[s] 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-427.1) and *Dependent Tax Affidavit for Domestic Partners* (PS-427.3) and submit the applicable proofs as outlined in *Instructions for Enrolling Domestic Partners* (PS-427). 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. An eligible child may be any of the following:

- 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

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 NYSHIP coverage.

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 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 verify the continued disability at minimum every seven years (frequency based on disabling condition)

by resubmitting the form and medical documentation. When your 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 four years of military service. By deducting the four years of military service from her age, we arrive at an adjusted eligibility age of 23. 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 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 NYSHIP 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 4) and *Dependent Eligibility* (page 5) 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
- Medicare card (if applicable)

Domestic partner*,**

- birth certificate
- Completed forms in the *Domestic Partner Series* (PS-427), 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 6.)*

- 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

**You must provide the Social Security Numbers of dependents when enrolling them for coverage.*

***Not all employers offer coverage to domestic partners (see Dependent Eligibility, page 5). 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 only. It does not cover your dependents, even if they are eligible for coverage.

If you do not enroll when first eligible, you will be subject to a late enrollment waiting period. Refer to "Effective date of coverage" in *Enrollment* on page 12 for more information.

Family Coverage

Family coverage provides benefits for you and the eligible dependents you elect to enroll. For more information on who can qualify as your dependent, see *Dependent Eligibility,* page 5.

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.)

When Your Dependent's Coverage Begins

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 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:

- **On or before a dependent's first date of eligibility**, your Family coverage will be effective on the date the dependent was first eligible.
- **Within 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 part 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 7.

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.

Changing Coverage

Changes in enrollment and the Pre-Tax Contribution Program (PTCP)

Enrollment in a Pre-Tax Contribution Program (PTCP) 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 (see the preceding section "When Your Dependent's Coverage Begins"). **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 5), 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 7.

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. Read the sections, *End Dates for Coverage* on page 19, *COBRA: Continuation of Coverage* on page 20 and *Young Adult Option* on page 32 and contact your Health Benefits Administrator to make any changes to your coverage.

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 a dependent(s) who was previously eligible but not enrolled, the late enrollment waiting period is waived and coverage for the dependent 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 7)

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.

When Coverage Ends

Refer to the section, *End Dates for Coverage*, page 19, 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 20 and *Young Adult Option* on page 32, or contact your Health Benefits Administrator.

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 *PA Health Insurance Transaction Form* (PS-503) and required proofs of eligibility to your Health Benefits Administrator.

When Coverage Begins

First date of eligibility

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

Example 1: *The eligibility rule your employer has established is the first of the month following the employee's hire date. If you are hired on September 10, your first date of eligibility 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. The eligibility rule your employer has established is the first day of the third month after the date you became eligible for NYSHIP coverage. Your first date of eligibility is February 1.*

Effective date of coverage

Once your first 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, your coverage will be effective on the first date of eligibility.
- within 30 days after the first date of eligibility, 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 day of eligibility, 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, your eligible dependent's enrollment will take effect on a current basis.

If you are changing from Individual to Family coverage to cover an eligible dependent, refer to "Changing from Individual to Family Coverage," page 10, in *Coverage: Individual or Family*.

If your dependent is eligible for NYSHIP, but not enrolled, you must submit a completed and signed *PA Health Insurance Transaction Form* (PS-503) to your Health Benefits Administrator to apply for coverage. Refer to *Proof of Eligibility*, page 7, 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 can be covered under NYSHIP if the same disability that qualified him/her as a disabled dependent while previously enrolled in NYSHIP again renders him/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 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 to cancel coverage. Your dependent may be eligible to continue coverage under COBRA (page 20), the Young Adult Option (page 32) or a direct-pay contract (page 23).

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, regardless of the number of dependents. 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

A Participating Agency is not required to contribute to the cost of dependent survivor coverage. If you are eligible for dependent survivor coverage, contact your Health Benefits Administrator for information.

COBRA Enrollees

Your employer is not obligated to contribute to 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, and may also be responsible for a two percent administrative fee. Refer to *COBRA: Continuation of Coverage* on page 20 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 Coverage* on page 32 for information.

Identification Cards

Upon enrollment in NYSHIP, a NYSHIP benefit card will be sent to the address on your enrollment record. This card includes your name and the names of your covered dependents (refer to page 63 of the *Appendix* for an example of your benefit card). Use this card 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 benefit card before you receive services, supplies or prescription drugs.

Your card will look different depending on what plan you are eligible for and enrolled in through your NYSHIP Participating Agency. See page 63 of the *Appendix* for samples of each card.

- Empire Plan enrollees will receive a NYSHIP benefit card, to be used for all services and supplies. Medicare-primary enrollees and dependents will be enrolled in Empire Plan Medicare Rx and each covered person will receive a separate card for prescription drugs. Use this card whenever you fill a

prescription. (See “Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan for Empire Plan Enrollees” in *Medicare and NYSHIP* in the second part of this book, page 49, for information and page 63 of the Appendix for a sample card.)

- Excelsior Plan enrollees will receive an Excelsior Plan benefit card, to be used for all services and supplies. Empire Plan Medicare Rx does not apply to Excelsior Plan enrollees or dependents.

Ordering a Card

Ask your Health Benefits Administrator to order a card if your or a dependent’s card is lost or damaged. Your new card will be sent to the address on your enrollment record. Please confirm that your address is correct.

Empire Plan enrollees: 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 68).

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 your dependent uses the card when 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 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 employment 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 or how you will 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 be eligible to 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 16, for details).

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act (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 to the premium.

You may have the right to apply for a waiver of your NYSHIP health insurance premium during the FMLA period (see the "Waiver of Premium" section on page 16 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.

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 11).

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 11). 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

Termination of employment

If your employment terminates, your last day of coverage will be the last day of the month in which you were eligible for coverage as an active employee and for which coverage was paid. At the end of this runout, you will no longer have health insurance coverage through NYSHIP unless you are eligible for and elect coverage as a retiree (see page 35) or vestee (see page 36), or elect COBRA coverage (see page 20). You may also be eligible to elect a direct-pay conversion contract (see page 23).

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 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.

Waiver of Premium

You may be entitled to have your Empire Plan or Excelsior Plan 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 or unpaid leave under FMLA. 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 cost of your health insurance premium while you were on leave without pay.

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 your employer if your waiver has been granted.

Additional waiver of premium

If you received a waiver of premium for up to one year, you must return to work before being eligible for an additional waiver of premium. If you have not returned to work, you may not use accruals to return to the payroll 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 consecutive 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 an 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 vest your health insurance coverage rights
- you retire
- you die
- you separate from service or are terminated

Dependent Survivor Coverage

Enrolled dependents may be eligible to continue NYSHIP coverage if the enrollee predeceases them. See below 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 on page 20 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 NYSHIP dependents continue to use the health insurance benefit cards they already have under the enrollee's identification number.

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 5)

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 20) or may be eligible to convert to a direct-pay contract (page 23).

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 the full premium. Check with the Health Benefits Administrator from the former employer for contribution rates.

Benefit Cards

After the extended benefits period ends, the primary dependent survivor becomes the enrollee, and a new identification number is issued. In most cases, this will be the spouse or domestic partner. A new NYSHIP benefit card (with the dependent survivor's name) and benefit information will be mailed to the dependent survivor.

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 your dependents lose eligibility for dependent survivor coverage under the New York State Health Insurance Program, they may be eligible to continue their coverage in NYSHIP under COBRA (see page 20) or convert to a direct-pay contract (see page 23).

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 NYSHIP eligibility requirements (see page 6)
- 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 20).

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 date your coverage ends. 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 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 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" and "Your 'other' child," on page 6 for special eligibility requirements). Your child up to age 30 may be eligible to enroll in NYSHIP coverage under the Young Adult Option (see *Young Adult Option*, page 32).

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-427.4] 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 Participating Agency employees and dependents enrolled in the New York State Health Insurance Program (NYSHIP). You must apply for COBRA coverage within 60 days from the date of loss of eligibility or 60 days from the date you are first informed of your eligibility, whichever date is later (see "Deadlines Apply," page 58). 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 coverage is lost as a result of a reduction in hours of employment or termination of employment
- NYSHIP coverage is canceled while you are 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 35] or vestee [page 36].)

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 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:

- a 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 10, in *Coverage: Individual or Family* for enrollment rules.)

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 5, and *Coverage: Individual or Family*, page 9). 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 29, to learn about 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 22 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.

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 continuation 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 Eligiblity" in *End Dates for Coverage*, page 19).

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. Your employer 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 continuation coverage, you will receive a bill for coverage. Ask your Health Benefits Administrator whether you will continue to 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 23).

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 your Health Benefits Administrator if you want to cancel your COBRA coverage.

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 68).

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.

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 your Health Benefits Administrator.

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

NYSHIP 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 survivor, as explained in *Dependent Survivor Coverage*, page 37)
- 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, or
- are eligible for Medicare due to age.

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 68).

Vestee Coverage

Note: Not all Participating Agencies offer NYSHIP coverage in retirement. This section only applies if you will be eligible to continue NYSHIP coverage as a retiree.

If your employment with a Participating Agency ends before you are eligible for coverage as a retiree and you meet the eligibility requirements listed 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
- as a dependent of a NYSHIP enrollee
- as an enrollee of another agency that offers NYSHIP coverage

Continuing NYSHIP Coverage as a Vestee

Eligibility

If your employment with a Participating Agency 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; and
- you have vested as a member of a retirement system administered by the State or one of its political subdivisions (such as a municipality); and
- you have met your employer's minimum service requirement (see "Eligibility Requirements for NYSHIP Coverage" on page 26 in *Eligibility to Continue Coverage as a Retiree*), but are not yet eligible to collect a pension at the time employment is terminated; and
- you are within five years of retirement eligibility (if your agency has adopted this requirement).

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.

Enrollment

For information on how to continue coverage as a vestee if your employment with a Participating Agency ends, contact your Health Benefits Administrator. Failure to apply in a timely manner can cause a lapse in 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.

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.

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.

Eligibility Requirements for NYSHIP Coverage

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

You will not be eligible to continue NYSHIP 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.

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 agency 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.

   School board members, unpaid board members: You must have a minimum of 20 years of service in your position to be 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 service with other public employers 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 about 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 retirement 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 above. This is referred to as "constructive retirement."

4. **Be enrolled in coverage through an employer that participates in NYSHIP.**

   You may satisfy this requirement by being enrolled at the time of retirement in:

   • NYSHIP as an enrollee or dependent

   • An alternative health benefit option provided by your NYSHIP participating employer

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, Local Housing Authority.*

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 26.
- **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 evaluated

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 67 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.

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 (enrollment in an employer buy-out may also satisfy this requirement; contact your Health Benefits Administrator). 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 you need it. 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 by your former employer 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.
- ☐ If you or your dependent is eligible for Medicare, regardless of age, Medicare Parts A and B provide coverage that is primary to NYSHIP when you retire (see *Medicare and NYSHIP,* page 46).

☐ **If you are moving when you retire**

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

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 21, 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 and 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-primary coverage as an employee enrolled in NYSHIP coverage, or when your enrolled dependent becomes eligible for Medicare that is primary to NYSHIP, it is the combination of health benefits under Medicare and NYSHIP that 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, and
- 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

Medicare eligibility begins:

- At age 65, or
- Regardless of age, after being entitled to Social Security Disability Insurance (SSDI) benefits for 24 months, or
- 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, 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:**

- 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 (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 Medicare-eligible due to disability and is under age 65 will receive primary coverage through NYSHIP while the enrollee is an active employee of a NYSHIP Participating Agency. Medicare becomes primary to NYSHIP once the enrollee retires or otherwise separates from service with a NYSHIP PA.

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 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 "Expenses Incurred Outside the United States," page 53.

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 timely, Medicare may 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 51.

Domestic partner eligible for Medicare due to age (65)

When to Apply:

Plan ahead. Three months before your domestic partner turns age 65, contact Social Security 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 68).

Example 1: *Josephine is employed by a New York State county 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 Josephine receives covered services, NYSHIP should receive claims first, and Medicare second.*

Example 2: *Juliette is an active employee of Fieldtown School District, and her husband, Jim, is a retiree from the incorporated village of Clear Lake. Both agencies participate in NYSHIP. Juliette is eligible for Medicare because she is over age 65. She has Individual coverage through Fieldtown School District and is covered by Jim 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 Jim's dependent 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, for additional information, refer to the following sections of *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 49
- "Medicare Costs, Payment and Reimbursement of Certain Premiums," page 51
- "Expenses Incurred Outside the United States," page 53
- "Provide Notice if Medicare Eligibility Ends," page 54

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 such 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

The young adult will have the same NYSHIP coverage that is available to 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 your employer 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, Vestees and Dependent Survivors of Participating Agencies

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

If you are still actively employed by a NYSHIP Participating Agency, including if you are receiving NYSHIP benefits while you are on a leave of absence, refer to the first part of this book, pages 3-33, for information.

Retiree Coverage

Eligibility requirements for NYSHIP coverage as a retiree are outlined in the portion of this book for Active employees, in the *Eligibility to Continue Coverage as a Retiree* section on page 25.

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 Excelsior Plan)
- type of coverage (Individual or Family coverage)
- eligibility for Medicare coverage primary to NYSHIP for you and/or your covered dependents

Also, you may be entitled to use the value of your unused sick leave to offset the cost of NYSHIP coverage in retirement. Contact your Health Benefits Administrator to find out if this provision is available to you, and if so, how it was 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 your former employer.

Suspending Enrollment

If you have other health insurance coverage and wish to discontinue your enrollment in NYSHIP, contact your Health Benefits Administrator.

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 your Health Benefits Administrator to cancel coverage. Your dependent may be eligible to continue coverage under COBRA (page 56), the Young Adult Option (page 61) or a direct-pay contract (page 60).

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 *PA Health Insurance Transaction Form* (PS-503) to your Health Benefits Administrator.

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.

Spouse with Independent Eligibility for NYSHIP

If your spouse 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 spouse maintains the right to reactivate his or her own NYSHIP enrollment at any time. For example, if you predecease your spouse, your spouse may either continue in NYSHIP as a dependent survivor or reactivate enrollment in his or her own right.

Other Resources

- Talk to your Health Benefits Administrator. After you retire, your Health Benefits Administrator will continue to assist you with coverage and enrollment. Be sure to write your Health Benefits Administrator's name and phone number on the first line of the *Contact Information* section in the back of this book.
- To report certain enrollment changes or address changes, contact your Health Benefits Administrator.
- Your *Certificate of Coverage* and annual *At A Glance* booklet provide information about benefits and coverage.
- The Department of Civil Service web site, https://www.cs.ny.gov, has current benefit information. Click on Benefit Programs, then NYSHIP Online.
- *On the Road with The Empire Plan* is a handy guide to your Empire Plan benefits when traveling.
- Medicare, which is administered by the Social Security Administration, can be reached at 1-800-MEDICARE (1-800-633-4227), or at the Medicare web site, www.medicare.gov, for medical benefits and claims information. Call Social Security at 1-800-772-1213 to enroll in Medicare.
- The *Medicare & NYSHIP* booklet and companion video explain how NYSHIP and Medicare work together to provide health benefits.
- *Medicare and NYSHIP* on page 46 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 Agency before you are eligible for coverage as a retiree), see *Vestee Coverage* on page 24 of the portion of this book for Active employees.

If you have continued coverage as a vestee, contact the Health Benefits Administrator at your former employer 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 25 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 below 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 death certificate to the Health Benefits Administrator at the former agency 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 on page 56 for information about 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 dependents continue to use the health insurance benefit cards they already have under the enrollee's identification number.

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 Health Benefits Administrator at the employing agency.

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 illness or 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 38).

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 56) or may be eligible to convert to a direct-pay contract (page 60).

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

Dependent survivors may be required to pay the full premium. Check with the Health Benefits Administrator at the former employer for contribution rates.

Benefit Cards for Dependent Survivors

After the extended benefits period ends, the primary dependent survivor becomes the enrollee, and a new identification number is issued. In most cases, this will be the spouse or domestic partner. Dependent survivors will be mailed benefit information and a new NYSHIP benefit card with the dependent survivor's name.

Dependent Eligible for NYSHIP as a Result of Employment

A dependent employed by or previously employed by 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 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 an enrollee. Survivors who were previously employed by a Participating Agency should write to the Participating Agency to ask about enrollment.

Loss of Eligibility for Dependent Survivor Coverage

If your dependents lose eligibility for dependent survivor coverage under NYSHIP, they may be eligible to continue their coverage under COBRA (see page 56) or convert to a direct-pay contract (see page 60).

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 NYSHIP eligibility requirements (see page 39)
- 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 page 43 for information regarding when your dependents' coverage begins. Dependent survivors, see above.

If your dependent is eligible for NYSHIP but not enrolled, contact your Health Benefits Administrator for enrollment information.

See *Proof of Eligibility* on page 41 for required proofs that must be submitted with the request to add a dependent to your coverage.

Note that waiting periods may apply when you enroll a dependent.

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 61 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

If your employer does not offer coverage to domestic partners, your domestic partner is not eligible to be covered as your dependent under NYSHIP and your domestic partner's children may not be eligible unless the child is eligible as an "other" child (see "Your 'other' child," page 40). ***Rules for domestic partners or children of domestic partners in this book apply only if that coverage is offered by your employer.*** *Ask your Health Benefits Administrator if your employer offers 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 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-427.1) and *Dependent Tax Affidavit for Domestic Partners* (PS-427.3) and submit the applicable proofs as outlined in *Instructions for Enrolling Domestic Partners* (PS-427). 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 and 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. An eligible child may be any of the following:

- 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

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.

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 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 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 verify the continued disability at minimum every seven years (frequency based on disabling condition) by resubmitting the form and medical documentation. When your 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. By deducting the four years of military service from her age, we arrive at an adjusted eligibility age of 23. 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 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 for coverage or to add a dependent to your coverage will not be processed by your Health Benefits Administrator without the required proof of eligibility. Refer to *Retiree Coverage* (page 35), *Vestee Coverage* (page 36), *Dependent Survivor Coverage* (page 37) and *Dependent Eligibility* (page 38) 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 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-427), 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 39.)*

- 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

**You must provide the Social Security Numbers of dependents when enrolling them for coverage.*

***Not all employers offer coverage to domestic partners (see Dependent Eligibility, page 38). 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 only. It does not cover your dependents, even if they are eligible for coverage.

If you do not enroll when first eligible, you will be subject to a late enrollment waiting period. Refer to "Effective date of coverage" in *Enrollment* on page 12 of the portion of this book for Active enrollees for more information.

Family Coverage

Family coverage provides benefits for you and the eligible dependents you elect to enroll. For more information on who can qualify as your dependent, see *Dependent Eligibility,* page 38.

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.)

When Your Dependent's Coverage Begins

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 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:

- **On or before a dependent's first date of eligibility**, your Family coverage will be effective on the date the dependent was first eligible.
- **Within 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 part 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 41.

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.

Changing Coverage

Changing from Individual to Family coverage

If you are changing to Family coverage because you acquired a new dependent (for example, you marry), your new coverage will begin according to when you apply (see the preceding section "When Your Dependent's Coverage Begins"). **Note:** The time frame for covering newborns is different (see the preceding "Covering Newborns").

If you are changing to Family coverage to add a dependent(s) who were 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 38), 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 names, dates of birth and Social Security numbers
- A copy of the Medicare card, if a dependent is eligible for Medicare

Additional documentation will be required. See *Proof of Eligibility* on page 41.

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. Read the sections, *End Dates for Coverage* on page 55, *COBRA: Continuation of Coverage* on page 56 and *Young Adult Option* on page 61 and contact your Health Benefits Administrator to make any changes to your coverage.

Enrollment Considered Late if Previously Eligible

If you or your dependent(s) were 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 a dependent who was previously eligible but not enrolled, the late enrollment waiting period is waived and coverage for the dependent 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

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.

When Coverage Ends

Refer to the section, *End Dates for Coverage,* page 55, for information about when your dependents' 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 56 and *Young Adult Option* on page 61, or contact your Health Benefits Administrator.

Identification Cards

Upon enrollment in NYSHIP, a NYSHIP benefit card will be sent to the address on your enrollment record. This card includes your name and the names of your covered dependents (refer to page 63 of the *Appendix* for an example of your benefit card). Use this card 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. You will not receive a new card when you retire.

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

Your card will look different depending on what plan you are eligible for and enrolled in through your NYSHIP Participating Agency (The Empire Plan or Excelsior Plan). See page 63 of the *Appendix* for samples of each card.

- Empire Plan enrollees will receive a NYSHIP benefit card, to be used for all services and supplies. Medicare-primary enrollees and dependents will be enrolled in Empire Plan Medicare Rx, and each covered person will receive a separate card for prescription drugs. Use this card whenever you fill a prescription. (See "Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan for Empire Plan Enrollees" in *Medicare and NYSHIP*, page 49, for information and page 63 of the *Appendix* for a sample card.)
- Excelsior Plan enrollees will receive an Excelsior Plan benefit card, to be used for all services and supplies. Empire Plan Medicare Rx does not apply to Excelsior Plan enrollees or dependents.

Ordering a Card

Ask your Health Benefits Administrator to order a 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.

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 68).

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 your dependent uses the card when 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 your Health Benefits Administrator immediately when you or your dependents are no longer eligible for NYSHIP coverage.

Your Premium

Note: Payment of premium does not establish eligibility for 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 your agency. Ask your Health Benefits Administrator what your cost will be each year.

Retirees

Your agency 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.

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 36, or *Young Adult Option Coverage,* page 61, for information.

Dependent Survivors

Contact your Health Benefits Administrator 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, and have been enrolled in NYSHIP with dependent coverage for at least 30 days with an employer contribution toward the cost of coverage, your dependents will be eligible for up to 12 months of Family coverage. To arrange for this benefit if you are going on active military duty, you or a family member must contact your Health Benefits Administrator 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 56, 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 and 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. You may also 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 standalone plans that provide 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, it is the combination of health benefits under Medicare and NYSHIP that 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, and
- 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 54.

When Medicare is primary for you and/or your covered dependents, The Empire Plan or Excelsior Plan will coordinate hospital, medical and mental health and substance abuse benefits with your traditional Medicare Parts A and B coverage. Refer to "Your Claims when Medicare is Primary" on page 52 of this section. Your Empire Plan 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 49 of this section.

When Medicare Eligibility Begins

Medicare eligibility begins:

- at age 65; or
- regardless of age, after being entitled to Social Security Disability Insurance (SSDI) benefits for 24 months; or
- 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 employment status of the enrollee, Medicare is primary for a domestic partner who is 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 53.

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 timely, Medicare may 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 your Health Benefits Administrator. 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 51).

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

When to Apply:

Plan ahead. Three months before you turn age 65, contact Social Security 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 on 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 Social Security 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 47 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 the Social Security Administration 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

Social Security may send you a Medicare card with an option to decline enrollment in Part B. **Do not decline.** If you declined Part B when Social Security offered it to you, and Medicare is your primary coverage, enroll now and send a photocopy of your new card to your Health Benefits Administrator.

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 at www.ssa.gov.

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

**This section does not apply to Excelsior Plan enrollees. Excelsior Plan prescription drug benefits are not affected by Medicare eligibility.*

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 below.

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 "Other Medicare prescription drug plans" below. Although in most cases you are not required to take any action, contact your Health Benefits Administrator immediately if:

- your automatic enrollment is rejected by CMS (for example, because you have no physical address on record), or
- if 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 your Health Benefits administrator 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 you 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 your Health Benefits Administrator.

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 63 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 45) 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 48 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 your Health Benefits Administrator 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 will be responsible for a Medicare Part B premium for your coverage and any covered dependents enrolled in Medicare when Medicare is primary to NYSHIP. The amount of the standard Medicare Part B premium is available on 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. Your former employer is required to reimburse you for this amount if you are eligible for reimbursement under NYSHIP rules (see "Medicare Part B IRMAA reimbursement" in 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 Social Security

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 48 of this section), your former employer will reimburse you the Medicare Part B premium and Medicare Part B IRMAA. You are not entitled to a reimbursement from your former employer 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 your Health Benefits Administrator if either of the above circumstances applies to you.

Your former employer 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), your former employer 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. Contact your Health Benefits Administrator to apply for reimbursement.

Standard Medicare Part B premium reimbursement

Your former employer can reimburse you for the standard Medicare Part B premium at a schedule of their own choosing (monthly, quarterly or annually). Contact your Health Benefits Administrator for information.

Medicare Part B IRMAA reimbursement

Contact your Health Benefits Administrator 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, which the SSA will provide to you in January for payments made the prior year or copies of billing statements from CMS.

Medicare Part D

**This section does not apply to Excelsior Plan enrollees. Excelsior Plan prescription drug benefits are not affected by Medicare eligibility.*

The Empire Plan provides 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. Your former employer is not required to reimburse Medicare Part D IRMAA.

Medicare Part D coverage is not a component of Excelsior Plan coverage.

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 Excelsior)

If you have questions about claims coordination with Medicare, contact the appropriate Empire Plan program administrator (see *Contact Information*, page 68).

Example 1: *Juliette is an active employee of Fieldtown School District, and her husband, Jim, is a retiree from the incorporated village of Clear Lake. Both agencies participate in NYSHIP. Juliette is eligible for Medicare because she is over age 65. She has Individual coverage through Fieldtown School District and is covered by Jim 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 Jim's dependent last.*

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

When you have coverage in addition to Medicare and NYSHIP

If you and/or your dependent also has coverage as an active employee through another 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

For covered services received outside the United States, file claims directly with your NYSHIP plan (see *Contact Information,* page 68). For more information, refer to your *Certificate of Coverage* and the publication *On The Road with The Empire Plan.*

Residing outside the United States

If you will be residing outside the United States, you must notify your Health Benefits Administrator. In most cases, Medicare will not cover services received outside of the United States; however, NYSHIP will provide benefits for covered services received outside 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 your Health Benefits Administrator for information on Medicare premium reimbursement and assistance with claims adjudication.

For information about filing claims, refer to your Empire Plan *Certificate of Coverage* 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 SSA if you enroll in Medicare at a later date (refer to "When You Are Required to Have Medicare Parts A and B in Effect," page 48 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 your Health Benefits Administrator of your new address. Ask that your Medicare Part B premium reimbursement resume.

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

- Contact Social Security 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 your Health Benefits Administrator.
- Contact your Health Benefits Administrator when you return and provide your new address and a copy of your current Medicare card. Ask your former employer 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 your Health Benefits Administrator.

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 your Health Benefits Administrator 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 your Health Benefits Administrator 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 42).
- *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. The employer you retired from 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 your Health Benefits Administrator 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 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 an adjusted age 26 for dependent children with qualifying military service [see page 40]). 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 40 for special eligibility requirements). Your child up to age 30 may be eligible to enroll in NYSHIP coverage under the Young Adult Option (see *Young Adult Option*, page 61).

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-427.4] to your Health Benefits Administrator.)

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 retirees and dependents enrolled in the New York State Health Insurance Program (NYSHIP). You must apply for COBRA coverage within 60 days from the date of loss of eligibility or 60 days from the date you are first informed of your eligibility, whichever date is later (see "Deadlines Apply," page 58). 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 year of coverage allowed/provided under Preferred List provisions is exhausted. (**Note:** You may be eligible to continue coverage as a retiree [see page 35] or vestee [see page 36].)

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.

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

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
- 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:

- a 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 43, in *Coverage: Individual or Family* for enrollment rules).

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 38, and *Coverage: Individual or Family,* page 42). 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.

Dependent survivors

If a surviving spouse remarries, eligibility for dependent survivor coverage is lost. (See "Loss of Eligibility for Dependent Survivor Coverage" in *Dependent Survivor Coverage,* page 37.)

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 48, to learn about 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," page 48). 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 59).
- 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.

Deadlines Apply

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 continuation coverage, the enrollee or covered dependent must notify your Health Benefits Administrator within 60 days from the date of the COBRA-qualifying event, for example:

- a divorce
- termination of a domestic partnership
- a child's loss of eligibility as a dependent under NYSHIP (see *Dependent Eligibility,* page 38).

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. Your former agency 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. Ask your Health Benefits Administrator whether you will continue to 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 60).

When You No Longer Qualify for COBRA Coverage

COBRA 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 your Health Benefits Administrator if you want to voluntarily cancel your COBRA coverage.

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 Medical/Surgical Program administrator (see *Contact Information,* page 68).

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.

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, deductible 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 your Health Benefits Administrator.

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

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 survivor, as outlined in *Dependent Survivor Coverage,* page 37)
- 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, or
- are eligible for Medicare due to age.

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 Plan administrator (see *Contact Information,* page 68).

Young Adult Option

The Young Adult Option allows the child of a NYSHIP enrollee to purchase Individual health insurance coverage through NYSHIP when such 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

The young adult will have the same coverage that is available to 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 your employer 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.

Appendix

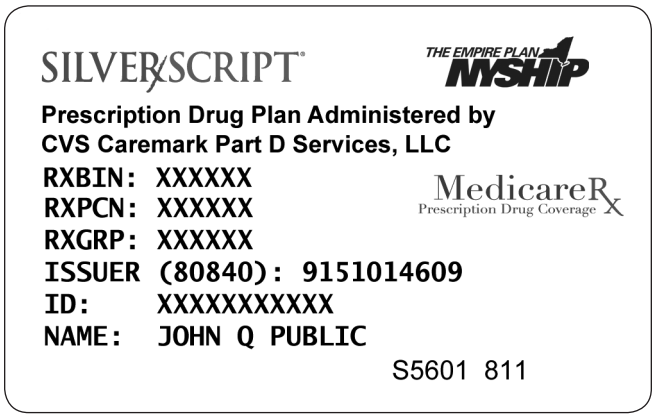
Empire Plan Cards

Empire Plan benefit card

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

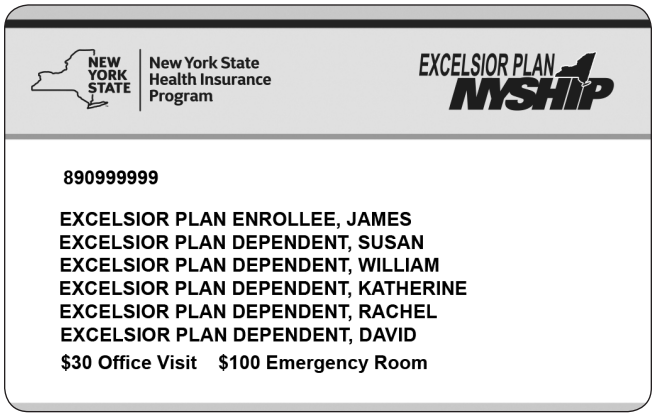
Empire Plan Medicare Rx card

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



Excelsior Plan benefit card

Present this card when you or your covered dependents receive services or supplies.



Retirement Check

If your NYSHIP premium is deducted from monthly New York State & Local Retirement Systems (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, 2014
Registration #:

NORMAL ALLOWANCE	C. O. L. A/ SUPPLEMENTAL	MEDICARE CREDIT			GROSS TOTAL
$2, 955.53	$15.00				$2,970.53
FEDERAL WITHHOLDING	INSURANCE PREMIUM				TOTAL DEDUCTIONS
	$372.25				$372.25
					CHECK AMOUNT
					$2,598.28

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

PA Health Insurance Transaction Form

Submit this form to your Health Benefits Administrator to make any enrollment changes.

NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
PA HEALTH INSURANCE TRANSACTION FORM
PS-503 (1/16)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name First Name MI	**2.** Social Security Number	**3.** Sex ☐ Male ☐ Female	
4. Mailing Address (If PO Box, complete box 5) City	State	Zip	
5. Home Address (If different from mailing address) City	State	Zip	
6. Date of Birth	**7.** Telephone Numbers Primary ( ) Work ( )	**8.** Work location and address	
9. Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	Marital Status Date		

10. Covered under Medicare? Self: ☐Yes ☐ No If yes, provide Medicare ID Number: _____

Spouse/Domestic Partner or Dependent: ☐Yes ☐ No name and Medicare Id Number: _____

11. DEPENDENT INFORMATION

Must be provided to enroll in family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete), C (Change), M (Medicare)
Date of Event: _____

Is enrollee or spouse reimbursed for Medicare by another agency?
☐**Yes** ☐ **No**

↓	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐A ☐D ☐C ☐M						
☐A ☐D ☐C ☐M						
☐A ☐D ☐C ☐M						
☐A ☐D ☐C ☐M						

12. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A OR B)

A. Enroll in New York State Health Insurance Plan (NYSHIP) Coverage: Choose options 1 or 2

1. **Individual Enrollment**	☐ Empire Plan	☐ Excelsior Plan
2. **Family Enrollment** *(Complete box 11)*	☐ Empire Plan	☐ Excelsior Plan

B. Decline New York State Health Insurance Plan (NYSHIP) Coverage ☐

13. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW

A. Change Coverage: Qualifying Event: _____ Date of Event: _____

☐ **Change to FAMILY** *(Complete box 11)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status
- ☐ Other: _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ Only dependent ineligible due to age
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Other: _____

B. Voluntarily Cancel Coverage: ☐ Qualifying Event: _____ Date of Event: _____

13. Continued	TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW
C. Change Retiree Payment Status	Change to: ☐ Pension Deduction (Rate: _____ / _____) ☐ Direct Payment to Agency
D. Correct Social Security Number	☐ Incorrect Social Security Number: _____

14. PREVIOUS COVERAGE INFORMATION

If you were previously covered under NYSHIP or another health insurance plan, please complete this section and attach proofs (i.e. insurance bill or letter stating former coverage).	Previous ID Number: _____	Date Coverage Terminated: _____	
	Enrollee's Name Under Which Previously Covered	Last Name	First Name MI

15. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY	☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed and must pay for this coverage.
	☐ I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.
RETIREMENT/ VESTEE STATUS	☐ I understand the requirements for continuing coverage as a retiree or vestee and wish to continue my coverage.
	☐ I understand the requirements for continuing coverage as a retiree or vestee and wish to defer my coverage.

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 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 *Summary of Benefits and Coverage* 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 1st Eligibility	Percentage Working	Agency Code	Eligibility Lost Date	Retirement System

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature (Required): _____ **Date:** _____

Disability Award Letter

If you are awarded a disability retirement, the effective date of your retirement is provided 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: nyslrsinfo@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.

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 1 OR SAY 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 2 OR SAY 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 3 OR SAY 3 — Mental Health and Substance Abuse Program

Administered by ValueOptions

Representatives are available 24 hours a day, seven days a week.

TTY: 1-855-643-1476

P.O. Box 1800
Latham, NY 12110

PRESS OR SAY 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

Other Agencies and Programs

NYS Retirement System 518-474-7736

TIAA/CREF 518-786-5900

Medicare – Social Security Administration 1-800-MEDICARE (1-800-633-4227)

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New York State
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
https://www.cs.ny.gov

Change Service Requested

Please do not send mail or correspondence to the return address above. See address information on page 68.

Important Health Insurance Information:
General Information Book for Active Employees and Retirees, Vestees and Dependent Survivors of Participating Agencies and their eligible dependents; also includes information regarding COBRA continuation coverage and the Young Adult Option

PA Active and Retiree/General Information Book – 2015

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).