AT A GLANCE | JANUARY 2020

PA | Participating Agencies

For Active Employees, Retirees, Vestees and Dependent Survivors enrolled in The Empire Plan through Participating Agencies, their enrolled Dependents and for COBRA Enrollees and Young Adult Option Enrollees with Empire Plan benefits.

This guide briefly describes Empire Plan benefits. It is not a complete description and is subject to change. For a complete description of your benefits and responsibilities, refer to your *Empire Plan Certificate* and *Certificate Amendments*.

For information regarding your New York State Health Insurance Program (NYSHIP) eligibility or enrollment, contact your Health Benefits Administrator. If you have questions regarding specific benefits or claims, contact the appropriate Empire Plan administrator (see page 23).

NEW YORK STATE | The Empire Plan

New York State Department of Civil Service, Employee Benefits Division, Albany, NY 12239
www.cs.ny.gov/employee-benefits

WHAT'S NEW

- **In-Network Out-of-Pocket Limit –** For 2020, the maximum out-of-pocket limit for covered, in-network services under The Empire Plan is $8,150 for Individual coverage and $16,300 for Family coverage, split between the Hospital, Medical/Surgical, Mental Health and Substance Abuse and Prescription Drug Programs. See page 3 for more information.
- **2020 Empire Plan Advanced Flexible Formulary Drug List –** The 2020 Advanced Flexible Formulary lists the most commonly prescribed generic and brand-name drugs along with any newly excluded drugs with formulary alternatives.
- **Hospice Care Coverage –** Effective July 1, 2019, enrollees are eligible for hospice care if the doctor and hospice medical director certify that the covered patient is terminally ill and likely has less than 12 months to live.
- **HPV Vaccine Coverage –** Effective October 1, 2019, enrollees age nine through 45 are covered for the human papillomavirus (HPV) 9 immunization at no cost when the vaccine is received from a participating provider. Other forms of HPV vaccines continue to be covered through age 26.
- **Infertility Benefits –** Effective January 1, 2020, Empire Plan infertility benefits will cover enrollees for a minimum of three IVF cycles per lifetime. Additionally, standard fertility preservation services are covered when a medical treatment, such as treatment for cancer (radiation therapy or chemotherapy), will directly or indirectly lead to infertility.
- **PrEP HIV-Prevention Medication Coverage –** Effective January 1, 2020, HIV-prevention medication for Pre-Exposure Prophylaxis (PrEP) will be covered with no copayment, deductible or any other out-of-pocket costs for enrollees who do not have HIV but are at high risk of acquiring it. Screening for HIV continues to be covered with no out-of-pocket costs when using a network provider.
- **Modified Solid Food Products Coverage –** Effective January 1, 2020, modified solid food products (MSFPs) are no longer subject to a $2,500 total maximum reimbursement per covered person, per year. Modified solid food products are covered when prescribed by a physician or provider. This benefit is not subject to deductible or coinsurance.

Quick Reference

The Empire Plan is a comprehensive health insurance program for New York's public employees and their families. The Plan has four main parts:

Hospital Program

administered by Empire BlueCross

Provides coverage for inpatient and outpatient services provided by a hospital or skilled nursing facility and hospice care. Includes the Center of Excellence for Transplants Program. Also provides inpatient Benefits Management Program services, including preadmission certification of hospital admissions and admission or transfer to a skilled nursing facility, concurrent reviews, discharge planning, inpatient medical case management and the Empire Plan Future Moms Program.

Medical/Surgical Program

administered by UnitedHealthcare

Provides coverage for medical services, such as office visits, convenience care clinics, surgery and diagnostic testing under the Participating Provider, Basic Medical and Basic Medical Provider Discount Programs. Coverage for physical therapy, chiropractic care and occupational therapy is provided through the Managed Physical Medicine Program.

Also provides coverage for home care services, durable medical equipment and related medical supplies through the Home Care Advocacy Program; the Prosthetics/Orthotics Network; Center of Excellence Programs for Cancer and for Infertility; and Benefits Management Program services, including Prospective Procedure Review for MRIs, MRAs, CT scans, PET scans, nuclear medicine tests, voluntary specialist consultant evaluation services, outpatient medical case management and the Empire Plan NurseLine℠ for health information and support.

Mental Health & Substance Abuse Program

administered by Beacon Health Options, Inc.

Provides coverage for inpatient and outpatient mental health care and substance use care services. Also provides preadmission certification of inpatient and certain outpatient services, concurrent reviews, case management and discharge planning.

Prescription Drug Program

administered by CVS Caremark

Provides coverage for prescription drugs dispensed through Empire Plan network pharmacies, the mail service pharmacy, the specialty pharmacy and non-network pharmacies.

See *Contact Information* on page 23.

Benefits Management Program

The Empire Plan Benefits Management Program helps to protect the enrollee and allows the Plan to continue to cover essential treatment for patients by coordinating care and avoiding unnecessary services. The Benefits Management Program precertifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient medical case management. In order to receive maximum benefits under the Plan, following the Benefits Management Program requirements — including obtaining precertification for certain services — is required when The Empire Plan is your primary coverage (pays first, before another health plan or Medicare).

YOU MUST CALL
for preadmission certification

If The Empire Plan is primary for you or your covered dependents, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program (administered by Empire BlueCross):

- Before a scheduled (nonemergency) hospital admission, skilled nursing facility admission/transfer or transplant surgery.*
- Before a maternity hospital admission.* Call as soon as a pregnancy is certain.
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.*

If you do not call and the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.

** These services are subject to a $200 penalty if the hospitalization is determined to be medically necessary, but not precertified.*

Other Benefits Management Program services provided by the Hospital Program include:

- Concurrent review of hospital inpatient treatment
- Discharge planning for medically necessary services post-hospitalization
- Inpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care
- The Empire Plan Future Moms Program for early risk identification and for online breastfeeding support

YOU MUST CALL
for Prospective Procedure Review

If The Empire Plan is primary for you or your covered dependents, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program (administered by UnitedHealthcare) before receiving the following scheduled (nonemergency) diagnostic tests:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computerized tomography (CT) scan
- Positron emission tomography (PET) scan
- Nuclear medicine test

Precertification is required unless you are having the test as an inpatient in a hospital. If you do not call, you will pay a larger part of the cost. If the test or procedure is determined not to be medically necessary, you will be responsible for the entire cost.

Other Benefits Management Program services provided by the Medical/Surgical Program include:

- Coordination of voluntary specialist consultant evaluation
- Outpatient medical case management for coordination of covered services for certain catastrophic and complex cases that may require extended care

Be sure to review the Benefits Management Program section of your *Empire Plan Certificate* and subsequent *Certificate Amendments* for complete information on the program's services and requirements.

Out-Of-Pocket Costs

In-Network Out-of-Pocket Limit

As a result of the federal Patient Protection and Affordable Care Act provisions, there is a limit on the amount you will pay out of pocket for in-network services/supplies received during the plan year.

Out-of-Pocket Limit: The amount you pay for network services/supplies is capped at the out-of-pocket limit. Network expenses include copayments you make to providers, facilities and pharmacies (network expenses do not include premiums, deductibles or coinsurance). Once the out-of-pocket limit is reached, network benefits are paid in full.

Beginning January 1, 2020, the out-of-pocket limits for in-network expenses are as follows:

Individual Coverage

- $5,300 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- $2,850 for in-network expenses incurred under the Prescription Drug Program*

Family Coverage

- $10,600 for in-network expenses incurred under the Hospital, Medical/Surgical and Mental Health and Substance Abuse Programs
- $5,700 for in-network expenses incurred under the Prescription Drug Program*

**** Does not apply to Medicare-primary enrollees or Medicare-primary dependents. Refer to your Empire Plan Medicare Rx documents for information about your out-of-pocket expenses.***

Out-of-Network Combined Annual Deductible

The combined annual deductible is $1,250 for the enrollee, $1,250 for the enrolled spouse/domestic partner and $1,250 for all dependent children combined.

The combined annual deductible must be met before Basic Medical Program expenses, non-network expenses under the Home Care Advocacy Program and outpatient, non-network expenses under the Mental Health and Substance Abuse Program will be considered for reimbursement.

Combined Annual Coinsurance Maximum

The combined annual coinsurance maximum is $3,750 for the enrollee, $3,750 for the enrolled spouse/domestic partner and $3,750 for all dependent children combined.

Coinsurance amounts incurred for non-network Hospital Program coverage, Basic Medical Program coverage and non-network Mental Health and Substance Abuse Program coverage count toward the combined annual coinsurance maximum. Copayments to Medical/Surgical Program participating providers and to Mental Health and Substance Abuse Program network practitioners also count toward the combined annual coinsurance maximum. (**Note:** Copayments made to network facilities do not count toward the combined annual coinsurance maximum.)

Preventive Care Services

Your Empire Plan benefits include provisions for expanded coverage of preventive health care services required by the federal Patient Protection and Affordable Care Act (PPACA).

When you meet established criteria (such as age, gender and risk factors) for certain preventive care services, those preventive services are provided to you at no cost when you use an Empire Plan participating provider or network facility. See the *2020 Empire Plan Preventive Care Coverage Chart* for examples of covered services.

For further information on PPACA preventive care services and criteria to receive preventive care services at no cost, visit www.hhs.gov/healthcare/rights/preventive-care.

Center Of Excellence Programs

For further information on any of the programs listed below, refer to your *Empire Plan Certificate* and the publication *Reporting On Center of Excellence Programs.* In some cases, a travel, lodging and meal allowance may be available. If you do not use a Center of Excellence, benefits are provided in accordance with Hospital and/or Medical/Surgical Program coverage.

Cancer Services*

YOU MUST CALL The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program or call the Cancer Resource Services toll free at 1-866-936-6002 and register to participate

Paid-in-full benefits are available for cancer services at a designated Center of Excellence. You will also receive nurse consultations, assistance locating cancer centers and a travel allowance, when applicable.

Transplants Program*

YOU MUST CALL The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Hospital Program for prior authorization

Paid-in-full benefits are available for the following transplant services when authorized by the Hospital Program and received at a designated Center of Excellence: pretransplant evaluation of transplant recipient; inpatient and outpatient hospital and physician services; and up to 12 months of follow-up care.

You must call The Empire Plan for preauthorization of the following transplants provided through the Center of Excellence for Transplants Program: bone marrow, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell and simultaneous kidney/pancreas. When applicable, a travel allowance is available. If you choose to have your transplant in a facility other than a designated Center of Excellence (or if you require a small bowel or multivisceral transplant) you may still take advantage of the Hospital Program case management services, in which a nurse will help you through the transplant process, if you enroll in the Center of Excellence for Transplants Program. If a transplant is authorized but you do not use a designated Center of Excellence, benefits will be provided in accordance with Hospital and/or Medical/Surgical Program coverage. **Note:** Transplant surgery preauthorization is required whether or not you choose to participate in the Center of Excellence for Transplants Program.

Infertility Benefits*

PRESS OR SAY 1 Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program for predetermination

Paid-in-full benefits are available, subject to the lifetime maximum for Qualified Procedures ($50,000 per covered person) including any applicable travel allowance, when you choose a Center of Excellence for Infertility. To request a list of Qualified Procedures, verify coverage of infertility benefits, or to find out how using a Center of Excellence offers you the highest level of benefits available for infertility care, call the Medical/Surgical Program.

The lifetime maximum applies to all covered hospital, medical, travel, lodging and meal expenses associated with the Qualified Procedure. If three IVF cycles have not been completed once the $50,000 lifetime maximum is reached, the Plan will cover the remaining IVF cycles until three have been met, including the associated travel, lodging and meal expenses.

Center of Excellence Program Travel Allowance

When you are enrolled in the Center of Excellence Program or use a Center of Excellence for preauthorized infertility services, a travel, lodging and meal expenses benefit is available for travel within the United States. The benefit is available to the patient and one travel companion when the facility is more than 100 miles (200 miles for airfare) from the patient's home. If the patient is a minor child, it will include coverage for up to two companions.

** Program requirements apply even if Medicare or another health plan is primary to The Empire Plan.*

Benefits will also be provided for one lodging per day. Reimbursement for lodging and meals will be limited to the U.S. General Services Administration per diem rate. Reimbursement for automobile mileage will be based on the Internal Revenue Service medical rate. Only the following travel expenses are reimbursable: lodging, meals, auto mileage (personal and rental car), economy class airfare and coach train fare. Once you arrive at your lodging and need transportation from your lodging to the Center of Excellence, certain costs of local travel are also reimbursable, including local subway, basic ridesharing, taxi or bus fare; shuttle; parking; and tolls.

Hospital Program

PRESS OR SAY 2 **Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 2 to reach the Hospital Program**

The Hospital Program provides benefits for services provided in a network or non-network inpatient or outpatient hospital, skilled nursing facility or hospice setting. Services and supplies must be covered and medically necessary, as defined in the current version of your *Empire Plan Certificate* or as amended in subsequent *Certificate Amendments*. The Medical/Surgical Program provides benefits for certain medical and surgical care when it is not covered by the Hospital Program.

Call the Hospital Program for preadmission certification or if you have questions about your benefits, coverage or an Explanation of Benefits statement.

Network coverage applies when you receive emergency or urgent services in a non-network hospital, or when you use a non-network hospital because you do not have access to a network hospital. Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Network Coverage

You pay only applicable copayments for services/supplies provided by a hospital, skilled nursing facility or hospice that is part of The Empire Plan network. No deductible or coinsurance applies. Network coverage also applies when The Empire Plan provides coverage that is secondary to other coverage.

Non-Network Coverage

When you use a facility that is not part of The Empire Plan network and do not qualify for network coverage (see above), your out-of-pocket costs are higher.

- You are responsible for a coinsurance amount of 10 percent of billed charges for inpatient facility services until you meet the combined annual coinsurance maximum.
- You are responsible for a coinsurance amount of 10 percent of billed charges or a $75 copayment, whichever is greater, for outpatient services until you meet the combined annual coinsurance maximum.

Hospital Inpatient

YOU MUST CALL
for preadmission certification (see page 2)

The Hospital Program covers you for a combined maximum of up to 365 days per spell of illness for inpatient diagnostic and therapeutic services or surgical care provided by a network and/or non-network hospital. Inpatient hospital coverage is provided under the Medical/Surgical Program's Basic Medical Program after Hospital Program benefits end.

Network Coverage

Inpatient stays in a network hospital are paid in full.

Non-Network Coverage

Inpatient stays in a non-network hospital are subject to a coinsurance amount of 10 percent of billed charges, until you meet the combined annual coinsurance maximum (see page 3). Network coverage is provided once the combined annual coinsurance maximum is satisfied.

Hospital Outpatient

Emergency Department

Network Coverage

You pay one $100 copayment per visit to an emergency department, including use of the facility for emergency care, services of the attending physician, services of providers who administer or interpret laboratory tests and electrocardiogram services. Other physician charges are covered under the Medical/Surgical Program (see page 7).

The copayment is waived if you are admitted as an inpatient directly from the emergency department.

Non-Network Coverage

Network coverage applies to emergency services received in a non-network hospital.

Outpatient Department or Hospital Extension Clinic

The hospital outpatient services covered under the Program are the same whether received in a network or non-network hospital outpatient department or in a network or non-network hospital extension clinic. The following benefits apply to services received in the outpatient department of a hospital or a hospital extension clinic.

Network Coverage

Outpatient surgery is subject to a $95 copayment.

You pay one $50 copayment per visit for diagnostic radiology and diagnostic laboratory tests.

You have paid-in-full benefits for:

- Preadmission and/or presurgical testing prior to an inpatient admission
- Chemotherapy
- Radiation therapy
- Anesthesiology
- Pathology
- Dialysis

The following services are paid in full when designated preventive according to the Patient Protection and Affordable Care Act:

- Bone mineral density tests
- Colonoscopies
- Mammograms*
- Pap smears
- Proctosigmoidoscopy screenings
- Sigmoidoscopy screenings

* *Screening, diagnostic and 3-D mammograms are paid in full under New York State law.*

Physical therapy following a related hospitalization or related inpatient or outpatient surgery is subject to a $25 copayment per visit. Physical therapy must start within six months from your discharge from the hospital or the date of your outpatient surgery and be completed within 365 days from the date of hospital discharge or outpatient surgery.

Non-Network Coverage

You are responsible for a coinsurance amount of 10 percent of billed charges or a $75 copayment (whichever is greater) per visit, until you meet the combined annual coinsurance maximum (see page 3). Network coverage is provided once the combined annual coinsurance maximum is satisfied.

Medically necessary physical therapy is covered under the Managed Physical Medicine Program when not covered under the Hospital Program (see page 12).

Skilled Nursing Facility Care

YOU MUST CALL
for preadmission certification (see page 2)

Benefits are subject to the requirements of the Empire Plan Benefits Management Program if The Empire Plan provides your primary health coverage. The Empire Plan does not provide skilled nursing facility benefits, even for short-term rehabilitative care, for retirees, vestees, and dependent survivors or their dependents who are eligible for primary benefits from Medicare.

Network Coverage

Skilled nursing facility care is paid in full when provided in place of hospitalization. Limitations apply; refer to your *Empire Plan Certificate* regarding conditions of coverage.

Non-Network Coverage

Skilled nursing facility care is covered when provided in place of hospitalization. You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum. Network coverage is provided once the combined annual coinsurance maximum is satisfied (see page 3).

Hospice Care

Network Coverage

Care provided by a licensed hospice program is paid in full. Refer to your *Empire Plan Certificate* regarding conditions of coverage.

Non-Network Coverage

You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum, for care provided by a licensed hospice program. Network coverage is provided once the combined annual coinsurance maximum is satisfied (see page 3).

Medical/Surgical Program Benefits for Physician/Provider Services Received in a Hospital Inpatient or Outpatient Setting

When you receive covered services from a physician or other provider in a hospital, and those services are billed by the provider (not the facility), the following Medical/Surgical Program benefits apply:

Participating Provider Program
Covered services are paid in full when the provider participates in The Empire Plan network.

Basic Medical Program
If you receive covered radiology, anesthesiology or pathology services in connection with covered inpatient or outpatient services at an Empire Plan network hospital and The Empire Plan provides your primary coverage, covered charges billed separately by the anesthesiologist, radiologist and pathologist will be paid in full by the Medical/Surgical Program. Services provided by other nonparticipating providers are subject to deductible and coinsurance.

Emergency care in a hospital emergency department is covered as follows:

- An attending emergency department physician is paid in full
- Participating or nonparticipating providers who administer or interpret radiological exams, laboratory tests, electrocardiogram exams and/or pathology are paid in full
- Other participating providers are paid in full
- Other nonparticipating providers (e.g., surgeons) are considered under the Basic Medical Program and are not subject to deductible and coinsurance

The Empire Plan provides additional protections to limit out-of-pocket expenses for patients who receive services from nonparticipating (non-network) providers at a network facility without their knowledge. See *Out-of-Network Reimbursement Disclosures* or contact the Medical/Surgical Program for more information.

Medical/Surgical Program

PRESS OR SAY 1 **Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 1 to reach the Medical/Surgical Program**

The Medical/Surgical Program covers services received from a physician or other practitioner licensed to provide medical/surgical services. It also covers services received from facilities not covered under the Hospital Program, such as outpatient surgical centers, imaging centers, laboratories, cardiac rehabilitation centers, urgent care centers and convenience care clinics. Services and supplies must be covered and medically necessary, as defined in the current version of your *Empire Plan Certificate* or as amended in subsequent *Certificate Amendments.* Call the Medical/Surgical Program if you have questions about coverage, benefits or the status of a provider.

Participating Provider Program

The Participating Provider Program provides medical/surgical benefits for services/supplies received from a provider that participates in The Empire Plan network.

When you receive covered services from a participating provider, you pay only applicable copayments. Women's health care services, many preventive care services and certain other covered services are paid in full (see pages 9-11).

The Plan does not guarantee that participating providers are available in all specialties or geographic locations.

Basic Medical Program

The Basic Medical Program provides benefits for services/supplies received from a provider that does not participate in The Empire Plan network. Your out-of-pocket costs are higher when you use a nonparticipating provider.

Combined annual deductible: The combined annual deductible must be satisfied before The Empire Plan reimburses for benefits received from a nonparticipating provider (see page 3).

Coinsurance: The Empire Plan reimburses 80 percent of the usual and customary rate for covered services after you meet the combined annual deductible. You are responsible for the balance.

Combined annual coinsurance maximum: After the combined annual coinsurance maximum is reached, The Empire Plan reimburses 100 percent of the usual and customary rate for covered services (see page 3).

Usual and Customary Rate (UCR): The lowest of the actual charge, the provider's usual charge or the usual charge within the same geographic area. The Plan generally utilizes FAIR Health© rates at the 90th percentile to determine the allowable amount. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the UCR for these services in your geographic area.

Basic Medical Provider Discount Program

If The Empire Plan is your primary insurance coverage and you use a nonparticipating provider who is part of The Empire Plan MultiPlan group, your out-of-pocket expense will, in most cases, be reduced. Your share of the cost will be based on the lesser of The Empire Plan MultiPlan fee schedule or the usual and customary rate.

The Empire Plan MultiPlan provider will submit bills to and receive payments directly from UnitedHealthcare. You are only responsible for the applicable deductible and coinsurance amounts. To find a provider, call the Medical/Surgical Program or go to www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, and select Find a Provider.

Office Visit/Office Surgery, Laboratory/Radiology and Contraceptives

Participating Provider Program

Office visits, including office surgery, may be subject to a single $25 copayment per visit. A single, separate $25 copayment may apply to laboratory services, radiology services and/or certain immunizations provided during the office visit. The costs of U.S. Food and Drug Administration (FDA)-approved contraceptive methods for women, including sterilization, that require physician intervention, are covered and are not subject to a copayment. Vasectomies are covered subject to copayment. Certain visits and laboratory/radiology services are not subject to copayment, including well-child care, prenatal care and visits for preventive care and women's health care.

Basic Medical Program

Covered services provided by or received from a nonparticipating provider are subject to Basic Medical Program benefits, including deductible and coinsurance.

Routine Health Exams

Participating Provider Program

Preventive routine health exams are paid in full.

Other covered services received during a routine health exam may be subject to copayment(s).

Basic Medical Program

Routine health exams are covered for active employees age 50 or older and for an active employee's spouse/domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance. Covered services, such as laboratory tests and screenings provided during a routine exam that fall outside the scope of a routine exam, are subject to deductible and coinsurance. For further information, contact the Medical/Surgical Program.

Adult Immunizations

Participating Provider Program

The following adult immunizations are paid in full, based on recommendations by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:

- Influenza (flu)*
- Pneumococcal (pneumonia)*
- Measles, mumps, rubella (MMR)
- Varicella (chickenpox)
- Tetanus, diphtheria, pertussis (Td/Tdap)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Meningococcal (meningitis)*
- Herpes zoster (shingles)*
  - Shingrix®
    No copayment is required for enrollees age 50 and older.
  - Zostavax®
    No copayment for enrollees age 60 and older; enrollees between the ages of 55 and 59 are subject to a Level 1, 30-day supply copayment at a network pharmacy or a medical copayment at a physician's office.

Basic Medical Program

Not covered.

Participating Provider Program

Doses, recommended ages and populations vary. Other immunizations may be subject to a copayment.

* *Paid in full under the Prescription Drug Program at pharmacies that participate in CVS Caremark's national vaccine network, subject to age limitations. See page 17 for vaccinations covered under the Prescription Drug Program.*

Routine Pediatric Care • *Up to age 19*

Participating Provider Program

Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and the cost of oral and injectable substances (including the influenza vaccine) when administered according to pediatric immunization guidelines.

Basic Medical Program

Routine newborn child care: Provider services for routine care of a newborn child are covered and not subject to deductible or coinsurance.

Routine pediatric care: Routine pediatric care provided by a nonparticipating provider is subject to Basic Medical Program benefits, including deductible and coinsurance.

Outpatient Surgical Locations

Participating Provider Program

A $50 copayment covers facility, same-day on-site testing, laboratory services provided on-site and anesthesiology charges for covered services at a participating outpatient surgical center.

Basic Medical Program

Covered services provided by a nonparticipating outpatient surgical center are subject to Basic Medical Program benefits, including deductible and coinsurance.

Hospital and hospital-based outpatient surgical locations are covered under the Hospital Program (see *Outpatient Department or Hospital Extension Clinic*, page 6).

Diabetes Education Centers

Participating Provider Program

Visits to a Diabetes Education Center are subject to a $25 copayment.

To find a Center, call the Medical/Surgical Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Find a Provider and then The Empire Plan Medical/Surgical Provider Directory.

Basic Medical Program

Visits to a nonparticipating Diabetes Education Center are subject to Basic Medical Program benefits, including deductible and coinsurance.

Prostheses and Orthotic Devices

Participating Provider Program

Prostheses/orthotic devices that meet the individual's functional needs are paid in full when obtained from a participating provider.

Basic Medical Program

Prostheses/orthotic devices that meet the individual's functional needs are subject to Basic Medical Program benefits, including deductible and coinsurance.

Hearing Aids

Basic Medical Program

Hearing aids, when prescribed by a licensed provider, including evaluation, fitting and purchase, are covered under the Basic Medical Program, up to a maximum reimbursement of $1,500 per hearing aid, per ear, once every four years. Children age 12 and under are covered up to $1,500 per hearing aid, per ear, once every two years if the existing hearing aid can no longer compensate for the child's hearing loss. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

Wigs

Basic Medical Program

Wigs are covered under the Basic Medical Program benefit, up to a $1,500 lifetime maximum, when hair loss is due to a chronic or acute medical condition. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

External Mastectomy Prostheses

Basic Medical Program

One single or double external mastectomy prosthesis is covered under the Basic Medical Program, once per calendar year. This benefit applies whether you use a participating or nonparticipating provider and is not subject to deductible or coinsurance.

You must call the Medical/Surgical Program and select the Home Care Advocacy Program for precertification of any single prosthesis costing $1,000 or more. For a prosthesis requiring prior approval, benefits will be available for the most cost-effective prosthesis that meets an individual's functional needs.

Gender Dysphoria Treatment

Participating Provider and Basic Medical Programs

Coverage includes cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Gender affirming surgery and other associated surgeries, services, and procedures, including those to change your physical appearance to more closely conform secondary sex characteristics to those of your identified gender, are covered when your behavioral health provider completes a determination of medical necessity.

Emergency Ambulance Service

Basic Medical Program

Local commercial ambulance transportation is a covered basic medical expense subject only to a $70 copayment. Volunteer ambulance transportation will continue to be reimbursed for donations at the current rates of $50 for under 50 miles and $75 for over 50 miles. This benefit applies whether you use an ambulance service that is a participating provider or a nonparticipating provider and is not subject to deductible or coinsurance.

Managed Physical Medicine Program

Administered by Managed Physical Network (MPN)

Chiropractic Treatment, Physical Therapy and Occupational Therapy

Network Coverage *(when you use MPN)*

Each office visit to an MPN provider is subject to a $25 copayment. Related radiology and diagnostic laboratory services billed by the MPN provider are subject to a separate $25 copayment. No more than two copayments per visit will be assessed.

MPN guarantees access to network benefits. If there are no network providers in your area, you must contact MPN prior to receiving services to arrange for network benefits.

Non-Network Coverage *(when you don't use MPN)*

Annual deductible: $250 enrollee; $250 enrolled spouse/domestic partner; $250 all dependent children combined. This deductible is separate from the combined annual deductible.

Coinsurance: The Empire Plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum. Coinsurance under the Managed Physical Medicine Program does not contribute to and is separate from the combined annual coinsurance maximum. The network allowance generally equates to 21 percent of FAIR Health© Usual and Customary professional rates.*

Home Care Advocacy Program (HCAP)

Home Care Services, Skilled Nursing Services and Durable Medical Equipment/Supplies

YOU MUST CALL
for prior authorization

Network Coverage *(when you use HCAP)*

To receive a paid-in-full benefit, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program, then Benefits Management Program, to precertify and help make arrangements for covered services, durable medical equipment and supplies, including one pair of diabetic shoes per year, insulin pumps, Medi-Jectors and enteral formulas. Diabetic shoes have an annual maximum benefit of $500.

Exceptions: For diabetic supplies (except insulin pumps and Medi-Jectors), call The Empire Plan Diabetic Supplies Pharmacy at 1-800-321-0591. For ostomy supplies, call Byram Healthcare Centers at 1-800-354-4054.

Non-Network Coverage *(when you don't use HCAP)*

The first 48 hours of nursing care are not covered. After you meet the combined annual deductible (see page 3), The Empire Plan pays up to 50 percent of the HCAP network allowance for covered services, durable medical equipment and supplies. There is no coinsurance maximum. You are also covered for one pair of diabetic shoes per year that are paid up to 75 percent of the HCAP network allowance with a $500 annual maximum. The network allowance generally equates to 38 percent of FAIR Health© Usual and Customary professional rates.*

Important: If Medicare is your primary coverage and you do not use a Medicare contract provider, your benefits will be reduced. If Medicare is your primary coverage and you live in an area or need supplies while visiting an area that participates in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, you must use a Medicare-approved supplier. To locate a Medicare contract supplier, visit www.medicare.gov/supplierdirectory/search.html or contact The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical/Surgical Program, then Benefits Management Program/Home Care Advocacy Program.

** Legislatively, the Department of Financial Services for the State of New York defines the term "Usual and Customary Rate (UCR)" as the 80th percentile of the FAIR Health© rates.*

Mental Health And Substance Abuse Program

PRESS OR SAY 3 **For the highest level of benefits, call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 3 to reach the Mental Health and Substance Abuse Program**

Call the Mental Health and Substance Abuse Program before seeking services from a mental health care or substance use care provider, including treatment for alcoholism and services that require precertification to confirm medical necessity before starting treatment (see list below). From there, you can reach the Clinical Referral Line, which is available 24 hours a day, every day of the year. You will receive the highest level of benefits when you follow the Program requirements for network coverage. You have guaranteed access to network benefits if you contact the Mental Health and Substance Abuse Program before you receive services. In an emergency, go to the nearest hospital emergency department. You or your designee should call the Mental Health and Substance Abuse Program within 48 hours of an admission for emergency care or as soon as reasonably possible.

Schedule of Benefits for Covered Services

The Program Administrator must certify all covered services as medically necessary, regardless of whether you are using Network or Non-Network coverage. If the Program Administrator does not certify your inpatient or outpatient treatment as medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

The following services require Precertification from the Program Administrator:

- Intensive outpatient program for mental health
- Structured outpatient program for substance use disorder
- 23-hour bed for mental health or substance use disorder
- 72-hour bed for mental health or substance use disorder
- Outpatient detoxification
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT) – inpatient and outpatient
- Applied Behavioral Analysis (ABA)
- Group home
- Halfway house
- Residential treatment center for mental health*
- Residential treatment center for substance use disorder**
- Partial hospitalization for mental health
- Partial hospitalization for substance use disorder

** Precertification is not required for covered individuals under 18 years of age at OHM-certified network facilities located within New York State.*

*** Precertification is not required for OASAS-certified Network Facilities located within New York State.*

Network Coverage

You pay only applicable copayments for covered services provided by a provider or facility that is in The Empire Plan network. No deductible or coinsurance applies.

Non-Network Coverage

When you use a provider or facility that is not in The Empire Plan network, your out-of-pocket costs are higher, as described in this section.

Inpatient Services

You should call before an admission to a mental health care or substance use care facility to ensure that benefits are available. In the case of an emergency admission, certification should be requested as soon as possible. Network facilities are responsible for obtaining precertification. If you use a non-network facility, you may be required to pay the full cost of any stay determined not to be medically necessary.

Network Coverage

Inpatient stays in an approved network facility are paid in full.

Practitioner treatment or consultation: Covered treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner — not the facility — are paid in full.

Non-Network Coverage

You will be responsible for a coinsurance amount of 10 percent of billed charges, up to the combined annual coinsurance maximum (see page 3). When the combined annual coinsurance maximum is met, you will receive network benefits.

Practitioner treatment or consultation: Covered treatment or consultation services that you receive while you are an inpatient that are billed by a practitioner — not the facility — are subject to deductible and coinsurance as described under *Office Visits and Other Outpatient Services*, page 14.

Ambulance Service

Ambulance service to a facility where you will be receiving mental health care or substance use care is covered at no cost to you when medically necessary. When the enrollee has no obligation to pay, donations up to $50 for trips of fewer than 50 miles and up to $75 for trips over the 50 miles will be reimbursed for voluntary ambulance services. This benefit is not subject to deductible or coinsurance.

Outpatient Services

Hospital Emergency Department

Network Coverage

You pay one $100 copayment per visit to an emergency department. The copayment is waived if you are admitted as an inpatient directly from the emergency department.

Non-Network Coverage

Network coverage applies to emergency department visits at a non-network hospital.

Office Visits and Other Outpatient Services

Network Coverage

Office visits and other outpatient services, such as outpatient substance use rehabilitation programs, psychological testing/evaluation, electroconvulsive therapy and Applied Behavior Analysis (ABA) services, may be subject to a $25 copayment per visit.

Up to three visits per crisis are paid in full for mental health care treatment. After the third visit, the $25 copayment per visit applies.

Non-Network Coverage

Combined annual deductible: Must be satisfied before The Empire Plan pays benefits (see page 3).

Coinsurance: The Empire Plan pays 80 percent of the usual and customary rate for covered services after you meet the combined annual deductible. You are responsible for the balance.

Combined annual coinsurance maximum: After the combined annual coinsurance maximum is reached, The Plan pays benefits for covered services at 100 percent of the UCR (see page 3).

Usual and Customary Rate (UCR): The lowest of the actual charge, the provider's usual charge or the usual charge within the same geographic area. The Plan generally utilizes FAIR Health© rates at the 90th percentile to determine the allowable amount. You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that will be charged, or by visiting www.fairhealthconsumer.org to determine the UCR for these services in your geographic area.

Prescription Drug Program

PRESS OR SAY 4 Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 4 to reach the Prescription Drug Program

This section DOES NOT APPLY if you are enrolled in Empire Plan Medicare Rx, the Medicare Part D prescription drug program (see page 19).

The Prescription Drug Program provides coverage for prescriptions for covered drugs, up to a 90-day supply, when filled at network, mail service, specialty or non-network pharmacies.

Copayments

You have the following copayments for covered drugs purchased from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy.

Drug Category	Up to a 30-day Supply from a Network Pharmacy, the Mail Service Pharmacy or the Specialty Pharmacy	31- to 90-day Supply from a Network Pharmacy	31- to 90-day Supply from the Mail Service Pharmacy or the Specialty Pharmacy
Level 1 Drugs or for Most **Generic** Drugs	$5	$10	$5
Level 2 Drugs, **Preferred** Drugs or Compound Drugs	$30	$60	$55
Level 3 Drugs or **Non-preferred** Drugs	$60	$120	$110

Drugs not Subject to Copayment

Certain covered drugs do not require a copayment when using a network pharmacy:

- Oral chemotherapy drugs, when prescribed for the treatment of cancer
- Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices), with up to a 12-month supply of contraceptives at one time without an initial 3-month supply
- Tamoxifen and raloxifene, when prescribed for the primary prevention of breast cancer
- Pre-Exposure Prophylaxis (PrEP), when prescribed for enrollees who are at high risk of acquiring HIV
- Certain preventive adult vaccines when administered by a licensed pharmacist at a pharmacy that participates in the CVS Caremark national vaccine network
- Certain prescription and over-the-counter medications* that are recommended for preventive services without cost sharing and have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF)

** When available over-the-counter, USPSTF “A” and “B” rated medications require a prescription order to process without cost sharing.*

Brand-Name Drugs with Generic Equivalent

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the Level 3 non-preferred drug copayment plus the ancillary charge, not to exceed the full retail cost of the covered drug.

Ancillary Charge: The difference in cost between the brand-name drug and the generic equivalent.

Exceptions

- If the brand-name drug has been placed on Level 1 of The Empire Plan Advanced Flexible Formulary, you will pay the Level 1 copayment.
- You pay only the applicable copayment for the following Level 3 brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. One copayment covers up to a 90-day supply.

Advanced Flexible Formulary Drug List

The Empire Plan Prescription Drug Program has a flexible formulary drug list for prescription drugs. The Empire Plan Advanced Flexible Formulary is designed to provide enrollees and the Plan with the best value in prescription drug spending.

This is accomplished by:

- Excluding coverage for certain brand-name or generic drugs if the drug has no clinical advantage over other covered medications in the same therapeutic class.
- Placing a brand-name drug on Level 1 or excluding or placing a generic drug on Level 3, subject to the appropriate copayment. These placements may be revised mid-year when such changes are advantageous to The Empire Plan. Enrollees will be notified in advance of such changes.
- Applying the highest copayment to non-preferred drugs that provide no clinical advantage over two or more Level 1 drug alternatives in the same therapeutic class. This may result in no Level 2 brand-name drugs.
- Including utilization management tools to promote transparency and reduce costs, not limited to generic substitution, prior authorization and physician education.

Prior Authorization Drugs

You must have prior authorization for certain drugs, including generic equivalents, noted with "PA" on the Empire Plan Advanced Flexible Formulary.

Certain medications also require prior authorization based on age, gender or quantity limit specifications. Compound drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization. **The drugs that require prior authorization are subject to change as drugs are approved by the U.S. Food and Drug Administration (FDA), introduced into the market or approved for additional indications.** For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then 2020 Drugs that Require Prior Authorization.

Excluded Drugs

Certain brand-name and generic drugs are excluded from The Empire Plan Flexible Formulary if they have no clinical advantage over other covered medications in the same therapeutic class. **The 2020 Empire Plan Advanced Flexible Formulary drug list includes drugs that are excluded in 2020, along with suggested alternatives.** New prescription drugs may be subject to exclusion when they first become available on the market. For a complete list of Excluded Drugs, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then 2020 Excluded Drug List. Also check the website for current information regarding exclusions of newly launched prescription drugs.

Medical Exception Program for Excluded Drugs

A medical exception program* is available for non-formulary drugs that are excluded from coverage.

To request a medical exception, you and your physician must first evaluate whether covered drugs on the Advanced Flexible Formulary are appropriate alternatives for your treatment. After an appropriate trial of formulary alternatives, your physician may submit a letter of medical necessity to CVS Caremark that details the formulary alternative trials and any other clinical documentation supporting medical necessity. The physician can fax the exception request to CVS Caremark at 1-888-487-9257.

** If you are Medicare primary, refer to your Empire Plan Medicare Rx plan materials for information regarding your appeal rights and the process to follow.*

If an exception is approved, the Level 1 copayment will apply for generic drugs and the Level 3 copayment will apply for brand-name drugs.

Note: Drugs that are only FDA approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

Types of Pharmacies

Network Pharmacy

A network pharmacy is a retail pharmacy that participates in the CVS Caremark network. When you visit a network pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail network pharmacy location that participates in the CVS Caremark network, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, and select Find a Provider.

CVS Caremark National Vaccine Network Pharmacy

Select preventive vaccines are covered without copayment when administered at a pharmacy that participates in the CVS Caremark national vaccine network. Vaccines available in a pharmacy are:

- Influenza (flu)
- Pneumococcal (pneumonia)
- Meningococcal (meningitis)
- Herpes zoster (shingles)* — *requires prescription*

To find out if a pharmacy participates in the CVS Caremark national vaccine network, call the Prescription Drug Program or visit www.empireplanrxprogram.com and select CVS Caremark, then Find a Local Pharmacy. Be sure to select Vaccine network under Advanced Search. Only certain pharmacies are part of the CVS Caremark national vaccine network. Call the pharmacy in advance to verify availability of the vaccine.

** Shingrix® is covered for individuals 50 and older at no copayment. Zostavax® is covered with no copayment for individuals 60 and older and at a Level 1, 30-day supply copayment for ages 55 to 59.*

Mail Service Pharmacy

You may request that your prescriber send your prescription to CVS Caremark Mail Service Pharmacy by using the mail order form. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone or online at www.empireplanrxprogram.com or download forms on NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted. Select Forms and scroll down to the CVS Caremark Mail Service Order Form.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services, including:

- Refill reminder calls
- Expedited, scheduled delivery of your medications at no additional charge
- All necessary supplies, such as needles and syringes applicable to the medication
- Disease education
- Drug education
- Compliance management
- Side-effect management
- Safety management

Prior authorization is required for some specialty medications. To get started with the CVS Caremark Specialty Pharmacy, to request refills or to speak to a specialty-trained pharmacist or nurse, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) Monday through Friday between 7:30 a.m. and 9 p.m. Eastern time. Choose the Prescription Drug Program, and ask to speak with Specialty Customer Care. If your call is urgent, you may request an on-call pharmacist 24 hours a day, seven days a week.

A complete list of specialty medications included in the Specialty Pharmacy Program is available on NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, select Using Your Benefits and then Specialty Pharmacy Drug List.

Non-Network Pharmacy

If you do not use a network pharmacy, or if you do not use your Empire Plan benefit card at a network pharmacy, you must submit a claim for reimbursement to: The Empire Plan Prescription Drug Program, c/o CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136.

In most cases, you will not be reimbursed the total amount you paid for the prescription.

- If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the Program would reimburse a network pharmacy for that prescription, less your copayment.
- If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the Program would reimburse a network pharmacy for filling the prescription with that drug's generic equivalent, less your copayment, unless the brand-name drug has been placed on Level 1 of The Empire Plan Advanced Flexible Formulary.

Empire Plan Medicare Rx Prescription Drug Program

PRESS OR SAY 4 Call The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and press or say 4 to reach the Prescription Drug Program

This section ONLY applies to Medicare-primary enrollees and dependents enrolled in Empire Plan Medicare Rx.

Empire Plan Medicare Rx is a Medicare Part D plan with expanded coverage designed specifically for Medicare-primary Empire Plan enrollees and dependents. Eligible individuals are automatically enrolled in Empire Plan Medicare Rx. Prior to enrollment, affected enrollees and dependents receive important information from SilverScript. Each Medicare-primary enrollee and Medicare-primary dependent will receive a unique Empire Plan Medicare Rx ID card from SilverScript to use at network pharmacies.

You have coverage for prescriptions for covered drugs, up to a 90-day supply, when filled at network, non-network or mail service pharmacies.

If you have questions, call the Prescription Drug Program or visit www.empireplanrxprogram.com.

Copayments

You have the following copayments for drugs purchased from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy.

Drug Category	Up to a 30-day (One Month) Supply of a Covered Drug from a Network Pharmacy, the Mail Service Pharmacy or the Specialty Pharmacy	31- to 90-day Supply of a Covered Drug from a Network Pharmacy	31- to 90-day Supply of a Covered Drug from the Mail Service Pharmacy or the Specialty Pharmacy
Tier 1 Drugs. Includes Most **Generic** Drugs	$5	$10	$5
Tier 2 Drugs. Includes **Preferred Brand** Drugs	$30	$60	$55
Tier 3 Drugs. Includes **Non-preferred** Brand-name Drugs	$60	$120	$110

Drugs not Subject to Copayment

Certain covered drugs do not require a copayment:

- Oral chemotherapy drugs, when prescribed for the treatment of cancer
- Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices)
- Tamoxifen and raloxifene, when prescribed for the primary prevention of breast cancer
- Pre-Exposure Prophylaxis (PrEP), when prescribed for enrollees who are at high risk of acquiring HIV
- Certain prescription and over-the-counter medications* that are recommended for preventive services without cost sharing and have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF).

** When available over-the-counter, USPSTF “A” and “B” rated medications require a Prescription order to process without cost sharing.*

Covered Drugs

Empire Plan Medicare Rx uses a formulary of Medicare Part D covered drugs and a secondary list of additional (non-Part D) covered drugs. Since Medicare Part D plans do not cover all types of drugs, the secondary list enhances the Medicare Part D covered drugs so that the coverage closely mirrors the drugs covered under The Empire Plan Advanced Flexible Formulary for non-Medicare enrollees.

The 2020 Empire Plan Medicare Rx Abridged Formulary is sent to all current members on an annual basis. It is included in an enrollment kit that Medicare-primary Empire Plan enrollees and dependents receive from SilverScript prior to enrolling in Empire Plan Medicare Rx. The 2020 Empire Plan Medicare Rx Comprehensive Formulary, a complete list of covered drugs, is also available online at www.empireplanrxprogram.com. If you have questions regarding the prescription drugs covered under Empire Plan Medicare Rx, call the Prescription Drug Program.

Note: Certain drugs are covered under Medicare Part B or Medicare Part D depending upon the circumstances for use. Additional information may be needed from the prescribing physician describing the use and setting of the drug to determine coverage under Medicare Part B or Medicare Part D. Prescription medications covered under Medicare Part B that are dispensed by a network pharmacy are subject to 20 percent coinsurance under Medicare and automatically crossed over to the Empire Plan Medical/Surgical Program for reimbursement. Please allow 4-6 weeks for reimbursement.

Empire Plan Medicare Rx ID Cards

Every Medicare-primary enrollee and every Medicare-primary dependent enrolled in Empire Plan Medicare Rx receives a separate, individualized prescription drug ID card from SilverScript. Each card provides a new unique ID number you can use at a network pharmacy when you fill your prescription medications. If you have questions, call the Prescription Drug Program.

Sample Empire Plan Medicare Rx ID card:

Sample Empire Plan card:

Continue to use your Empire Plan card 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 this card for their prescription drugs.

Prior Authorization Program

Certain medications require prior authorization based on diagnosis, clinical condition or quantity limit specifications. For information about prior authorization requirements, or the current list of drugs requiring authorization, call the Prescription Drug Program.

Types of Pharmacies

Network Pharmacy

A network pharmacy is a retail pharmacy that participates in the CVS Caremark network. When you visit a network pharmacy to fill a prescription, you pay a copayment (and ancillary charge, if applicable). To find a retail network pharmacy location that participates in the CVS Caremark network, call the Prescription Drug Program or go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, and select Find a Provider.

Mail Service Pharmacy

You may fill your prescription by mail through the CVS Caremark Mail Service Pharmacy by using the mail order form. For forms and refill orders, call the Prescription Drug Program. To refill a prescription on file with the mail service pharmacy, you may order by phone or online at www.empireplanrxprogram.com.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services including:

- Refill reminder calls
- Expedited, scheduled delivery of your medications at no additional charge
- All necessary supplies, such as needles and syringes applicable to the medication
- Disease education
- Drug education
- Compliance management
- Side-effect management
- Safety management

For a complete list of specialty medications included in the Specialty Pharmacy Program, visit www.empireplanrxprogram.com. Prior authorization is required for some specialty medications.

To get started with the CVS Caremark Specialty Pharmacy, to request refills or to speak to a specialty-trained pharmacist or nurse, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) Monday through Friday between 7:30 a.m. and 9 p.m. Eastern time. Choose the Prescription Drug Program, and ask to speak with Specialty Customer Care. If your call is urgent, you may request an on-call pharmacist 24 hours a day, seven days a week.

Non-Network Pharmacy

If you do not use a network pharmacy, or if you do not use your Empire Plan Medicare Rx benefit card at a network pharmacy, you must submit a claim for reimbursement to: The Empire Plan Medicare Rx Prescription Drug Program, c/o CVS Caremark, P.O. Box 52066, Phoenix, AZ 85072-2066.

In most cases, you will not be reimbursed the total amount you paid for the prescription. This plan will process out-of-network paper claim member reimbursements at 100 percent submitted charges less the enrollee's copayment.

Benefits on the Web

NYSHIP Online is a complete resource for your health insurance benefits, including:

- Current publications describing your benefits and plan
- Announcements
- An event calendar
- Prescription drug information
- Contact information
- Links to all Empire Plan program administrator websites

To find the most up-to-date information about your health insurance coverage, go to NYSHIP Online at www.cs.ny.gov/employee-benefits. (Retirees select Click here for NYSHIP Online for RETIREES.) Choose your group and plan, if prompted, to get to the NYSHIP Online homepage. You can bookmark this page to bypass the login screen the next time you sign in.

Contact Information

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select the appropriate program.

PRESS 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 Claims submission fax: 845-336-7716 Online submission: https://nyrmo.optummessenger.com/public/opensubmit
PRESS OR SAY 2	**Hospital Program: *Administered by Empire BlueCross*** Administrative services are provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans. 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 Claims submission fax: 888-367-9788 Online form: www.empireblue.com/forms/
PRESS OR SAY 3	**Mental Health and Substance Abuse Program: *Administered by Beacon Health Options, Inc.*** Representatives are available 24 hours a day, seven days a week. TTY: 1-855-643-1476 P.O. Box 1850, Hicksville, NY 11802 Claims submission fax: 855-378-8309 Online form: www.achievesolutions.net/achievesolutions/en/empireplan/Home.do
PRESS OR SAY 4	**Prescription Drug Program: *Administered by CVS Caremark*** Representatives are available 24 hours a day, seven days a week. TTY: 711 Customer Care Correspondence, P.O. Box 6590, Lee's Summit, MO 64064-6590 **Medicare Rx Prescription Drug Program** TTY: 711 SilverScript Insurance Company, P.O. Box 52066, Phoenix, AZ 85072-2066
PRESS OR SAY 5	**Empire Plan NurseLine℠: *Administered by UnitedHealthcare*** Registered nurses are available 24 hours a day, seven days a week to answer health-related questions.

This document provides a brief look at Empire Plan benefits for Participating Agency enrollees. Use it with your *Empire Plan Certificate* and *Empire Plan Reports*. If you have questions, call *1-877-7-NYSHIP (1-877-769-7447)* and choose the program you need.

NEW YORK STATE | **NYSHIP** New York State Health Insurance Program

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

518-457-5754 or 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
www.cs.ny.gov

The *Empire Plan At A Glance* is published by the Employee Benefits Division of the New York State Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits through The Empire Plan.

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Employee Benefits Division
P.O. Box 1068
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NEW YORK STATE | **NYSHIP**
New York State
Health Insurance Program

Information for the Enrollee, Enrolled Spouse/
Domestic Partner and Other Enrolled Dependents

Participating Agencies At A Glance — January 2020

Please do not send mail or correspondence to the return address above. See boxed address page 23.

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. These publications are also available on NYSHIP Online at www.cs.ny.gov/employee-benefits. Visit NYSHIP Online for timely information that meets universal accessibility standards adopted by New York State for NYS agency websites. If you need an auxiliary aid or service to make benefits information available to you, please contact your Health Benefits Administrator (HBA). COBRA Enrollees: Contact your former HBA.

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The Empire Plan Copayments at a Glance

The listed copayments apply when services are received under the Participating Provider Program or network coverage. Preventive care services under the Patient Protection and Affordable Care Act, women's health care services and certain other covered services are not subject to copayment.

Medical/Surgical Program	$25 copayment – Office visit, office surgery, radiology, diagnostic laboratory tests, freestanding cardiac rehabilitation center visit, convenience care clinic visit $30 copayment – Urgent care center visit $50 copayment – Non-hospital outpatient surgical locations $70 copayment – Licensed ambulance service **Chiropractic treatment or physical therapy services (Managed Physical Medicine Program)** $25 copayment – Office visit, radiology, diagnostic laboratory tests
Hospital Program	$25 copayment – Outpatient physical therapy $50 copayment – Urgent care center visit, outpatient services for diagnostic radiology and diagnostic laboratory tests $95 copayment – Outpatient surgery $100 copayment – Emergency department visit
Mental Health and Substance Abuse Program	$25 copayment – Visit to an outpatient substance use treatment program $25 copayment – Visit to a mental health professional $100 copayment – Emergency department visit
Prescription Drug Program	Up to a 90-day supply from a network pharmacy, the mail service pharmacy or the designated specialty pharmacy (see The Empire Plan Prescription Drug Program copayment chart on page 15 or the Empire Plan Medicare Rx Program copayment chart on page 19).

NEW YORK STATE | NYSHIP
New York State
Health Insurance Program

2020 General Information Book

Participating Employers

New York State Health Insurance Program

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

New York State Department of Civil Service, Employee Benefits Division • www.cs.ny.gov/employee-benefits

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General Information Book

General Information Book

Introduction

This is the *New York State Health Insurance Program (NYSHIP) General Information Book* for individuals and their covered dependents enrolled in NYSHIP through a NYSHIP Participating Employer (PE). This book explains certain rights and responsibilities you have as an enrollee in NYSHIP. Receipt of this book does not guarantee you are eligible for or enrolled in coverage.

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

This book has two sections. The first section, beginning on page 3, applies to active employees.

The second section, beginning on page 43, applies when you are no longer working for the employer that provides you with your NYSHIP coverage, such as when you are covered as a retiree, vestee, dependent survivor, dependent of an enrollee who is no longer an active employee or as an enrollee in Preferred List status (Preferred List applies only to former employees who have been laid off).

Refer to the appropriate section of the book for information.

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

Therefore, the information in this book is subject to change, and you will be notified of changes through mailings to your address as it appears on your NYSHIP record. Please make sure that your HBA or EBD has your most current address. Amendments and notification of changes also can be found on NYSHIP online: www.cs.ny.gov/employee-benefits.

When You Need Assistance

When you are an active employee, your HBA, 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 HBA know of any changes that may affect your NYSHIP coverage.

When You Must Contact Your HBA

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

Your mailing address changes or your home address changes. (If you or a covered dependent is Medicare primary and your mailing address is a P.O. Box, your HBA 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 7 [active] or page 50 [retiree] for details).

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

Your employment status is changing.

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

Your Medicare status is changing.

- You or a covered dependent becomes eligible for primary Medicare benefits (see *Medicare and NYSHIP*, page 31 [active] or page 59 [retiree])
- You or a covered dependent loses eligibility for primary Medicare benefits (see *Medicare and NYSHIP*, page 31 [active] or page 59 [retiree])

Other reasons to contact your HBA:

- You need to order a replacement or additional NYSHIP benefit card
- You have questions about the amount of your premium or your bill for NYSHIP coverage
- You want to cancel or reinstate your coverage
- You have questions about Consolidated Omnibus Reconciliation Act (COBRA) continuation of coverage (see page 36) or Young Adult Option coverage (see page 40)

Questions About Your Benefits

Empire Plan inquiries: For questions on specific benefits or claims, or to locate a provider, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate program. See *Contact Information*, page 78, for details.

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

Benefits on the Web

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

General Information Book

For Active Employees of Participating Employers

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

After you have retired or separated from service with a NYSHIP Participating Employer, or if you are a dependent survivor, refer to the second part of this book, pages 43-74, for information.

Your Options Under NYSHIP

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

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

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

For details about The Empire Plan and NYSHIP HMOs, refer to the *Health Insurance Choices* booklet, issued annually, usually in November or December. You may obtain a copy of *Health Insurance Choices* from your HBA, usually located in your personnel office or you can access it on NYSHIP Online.

The Empire Plan or a NYSHIP HMO

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

- Hospitalization and related expense coverage
- Medical/surgical care coverage
- Mental health and substance use treatment coverage
- Prescription drug coverage*

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

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

** Not all Participating Employers provide prescription drug coverage.*

Annual Option Transfer Period

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

> The annual Option Transfer Period is not an open enrollment period. If you and/or your dependents were previously eligible for NYSHIP coverage and did not enroll when it was first offered but then later decided to enroll, you may be subject to a late enrollment waiting period before coverage begins.

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

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

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

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

- You are no longer eligible to continue coverage in your current HMO because you move permanently out of your current HMO's service area or your job's location changes and is no longer located in your current HMO's service area. To keep NYSHIP coverage, you must choose The Empire Plan or a different HMO that serves your new area.
- You move permanently or your job's location changes and you want to change to an HMO that was not available where you previously lived or worked. You may change to the newly available HMO regardless of what option you were in before you moved.
- Your dependent moves permanently and is no longer in your HMO's service area. (**Note:** A student attending college outside your HMO's service area is not considered a change in permanent residence.)
- You add a newly eligible dependent to your coverage in a timely manner (see pages 13-14 for time frames). The dependent may be acquired through marriage, domestic partnership, birth, adoption, placement for adoption or if your child meets the "other" child eligibility criteria (see page 10).
- You return to your employer's payroll after military leave.
- You return to your employer's payroll after a break in service, if you were ineligible to continue enrollment during the break.
- You return to your employer's payroll after going on leave without pay and an Option Transfer Period occurred while you were on leave. You may select any option when you reenroll.
- You retire or vest your health insurance.

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

All requests to change options must be made in a timely manner, no later than 30 days after your qualifying life event, to ensure you have continued access to benefits.

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

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

Consider Carefully

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

Employee Eligibility

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

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).

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

- You must be appointed/elected to a benefits-eligible position with a NYSHIP Participating Employer.
- You must be on the payroll at the time you enroll. If you begin work, then take an unpaid leave of absence, you are not eligible until you return to the payroll and complete any waiting period established by your employer, including days worked before your leave began.

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

Eligibility Requirements for Coverage

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

1. You are expected to work at least three months. (**Note:** This requirement does not apply to paid elected officials.)
2. You work a regular schedule of 20 hours or more per week; ***or***

   You are paid an annual salary at a rate of $2,000 or more per year ***or***

   You meet **one** of the following criteria:

   - You are a local elected official
   - You are a paid member of a public legislative body
   - You are an unpaid board member of a public authority with at least six months' service as a board member
   - Your public employment provides the major source of your family's income
3. You are not already enrolled in NYSHIP as the result of your current or former employment.

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

- A longer anticipated term of employment up to a maximum of six months ***or***
- A regular schedule of more than 20 hours per week ***or***
- A required minimum annual salary of more than $2,000 per year ***or***
- Work week or annual salary eligibility requirements for local elected officials, paid members of public legislative bodies or elected members of school boards

Employer discretion based on class or category of employee

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

Dual Coverage in NYSHIP

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

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

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

Example: *Linda and her spouse, Bob, are both eligible for NYSHIP as the result of their active employment. Linda works for Public Authority A and Bob works for Public Authority B. Linda may be covered by her employer under NYSHIP as the enrollee and also as a dependent on Bob's NYSHIP policy.*

Dependent Eligibility

You may cover your eligible dependents under NYSHIP by enrolling in Family coverage or adding eligible dependents to existing Family coverage. Dependents who meet the requirements described in this section are eligible for NYSHIP coverage. To enroll your dependent who is eligible for NYSHIP but not enrolled, contact your HBA.

See *Proof of Eligibility* on page 9 for required proofs that must be submitted with the request to add a dependent to your coverage. For information about when coverage will take effect, see page 12.

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

Your Spouse

Your spouse, including a legally separated spouse, is eligible for NYSHIP coverage. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to provide coverage (you and/or your ex-spouse must provide a copy of the divorce decree to your HBA).

Your Domestic Partner

Ask your HBA if your employer offers coverage to domestic partners. If your employer does not offer coverage to domestic partners, your domestic partner is not eligible to be covered as your dependent under NYSHIP. Your domestic partner's child(ren) also may not be eligible, unless eligible as "other" children (see page 10). **Eligibility and coverage rules for domestic partners or children of domestic partners in this book apply only if that coverage is offered by your employer.**

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

- Are both 18 years of age or older
- Have been in the partnership for at least six months
- Are both unmarried (copy of divorce decrees or death certificate(s) required, if applicable)
- Are not related in a way that would bar marriage in New York State

- Have shared the same residence and have been financially interdependent for at least six months
- 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 *NYSHIP Domestic Partner Enrollment Application* (PS-425) and submit the applicable proofs as outlined in the application to your HBA. 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 your domestic partner's coverage, referred to as imputed income, is considered to be a taxable fringe benefit. The imputed income will increase your taxable gross income for federal and state income taxes, as well as Social Security and Medicare payroll taxes. Check with your HBA to find out how imputed income is reported and for an approximation of the fair market value for domestic partner coverage. You may also ask a tax consultant how enrolling a domestic partner will affect your taxes.

Your Children

The following children are eligible for coverage until age 26:

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

Your "other" child

You may cover "other" children:

- Who are financially dependent on you
- Who reside with you

The above requirements must be reached before the "other" child is age 19. You must file the form *NYSHIP Statement of Dependence for "Other" Children* (PS-457), verify eligibility and provide documentation to your HBA 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 they would otherwise have lost eligibility due to age

Contact your HBA 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 *NYSHIP Statement of Disability* (PS-451) and provide medical documentation. You will be asked to complete the *NYSHIP Statement of Disability* form and provide medical documentation to certify the child's disability — at minimum — every seven years (frequency based on disabling condition). If a disabled dependent is also an "other" child, you will be required to resubmit the form *NYSHIP Statement of Dependence for "Other" Children* (PS-457) every two years (at minimum).

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

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

- Be enrolled in school on a full-time basis
- Be unmarried and
- Not be eligible for other employer group coverage

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

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

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

Proof of Eligibility

Your application to enroll or to add a dependent to your coverage will not be processed by your HBA without required proof of eligibility. If the required proofs are not immediately available, you should submit your application and advise your HBA that you will provide the required documentation as soon as it becomes available. If documentation is not provided within 30 days of your application, you and/or your dependents may be subject to a late enrollment waiting period. Refer to *Employee Eligibility* (page 6) and *Dependent Eligibility* (page 7) for eligibility requirements.

Required Proofs

You must provide the following proofs to your HBA:

You, the enrollee

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

Spouse*

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

Domestic partner*,**

- Birth certificate
- Completed *NYSHIP Domestic Partner Enrollment Application* (PS-425) with appropriate proof as required in the application
- Medicare card (if applicable)

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

- Birth certificate
- Medicare card (if applicable)

Adopted children*

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

Your disabled child over age 26*

- Birth certificate
- Completed form *NYSHIP Statement of Disability* (PS-451) with appropriate documentation as required in the application
- Medicare card (if applicable)

"Other" children*

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

- Birth certificate
- Completed form *NYSHIP Statement of Dependence for "Other" Children* (PS-457) with appropriate documentation as required in the application
- Medicare card (if applicable)

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

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

* ***Provide the Social Security numbers of dependents when enrolling them for coverage.*** *Contact your HBA if no Social Security number is assigned.*

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

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

Coverage: Individual or Family

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

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

Individual Coverage

Individual coverage provides benefits for you only. It does not cover your dependents, even if they are eligible for coverage. If you do not enroll when first eligible, you may be subject to a late enrollment waiting period. Refer to *First date of eligibility* on page 14 for more information.

Family Coverage

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

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

- One Family coverage
- Two Individual coverages
- One Family coverage and one Individual coverage
- Two Family coverages, if both of your employers permit two Family coverages

Note: New York State does not permit two Family coverages. If one spouse (or domestic partner, if your employer offers NYSHIP coverage for domestic partners) enrolls as an employee of New York State, only one of you may elect Family coverage. The other may only elect Individual coverage.

Enrollment

Enrollment Is Not Automatic

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

To have coverage in effect on your first date of eligibility for coverage (see below), be sure to submit the form before that date. You will also need to submit required proofs of eligibility to your HBA. If you choose a NYSHIP HMO, the HMO may require you to file an additional form. If you do not apply when first eligible for coverage, you will be considered a late enrollee and will be subject to a waiting period before coverage is effective (see below).

When Coverage Begins

First date of eligibility

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

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

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

Effective date of coverage

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

- **On or before the first date of eligibility**, your coverage will be effective on the first date of eligibility for coverage
- **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 date 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 your dependent is eligible for NYSHIP, but not enrolled, you must submit a completed and signed *Health Insurance Transaction Form* (PS-404) to your HBA to enroll them in coverage. Refer to *Proof of Eligibility*, page 9, for documentation that will be required upon enrollment.

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

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

If you are changing from Individual to Family coverage to cover an eligible dependent, refer to *Changing from Individual to Family Coverage*, page 13.

Reenrolling dependents

Dependents who lose eligibility can again be covered under NYSHIP if eligibility is restored. For example, unmarried, disabled dependent children who lost eligibility because they were no longer disabled can again be covered under NYSHIP if the same disability that qualified them as disabled dependents while previously enrolled in NYSHIP again renders them 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.

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. This is known as the late enrollment waiting period.

A late enrollment waiting period will be waived if the other coverage terminates and you notify your HBA within 30 days of the date the other coverage terminated.

Exception: Dependents affected by National Medical Support Order

If a National Medical Support Order requires you to provide coverage to your previously eligible but not enrolled dependent(s), the late enrollment waiting period is waived and coverage for your dependent(s)

will be effective on the date indicated on the National Medical Support Order. Contact your HBA 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 9)

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

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

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

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

Canceling Enrollment

To cancel your enrollment in NYSHIP, contact your HBA.

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.

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 HBA. Your dependent may be eligible to continue coverage under COBRA (page 36), the Young Adult Option (page 40) or a direct-pay contract (page 41).

Changing Coverage

Changes in enrollment and a pre-tax contribution program

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

Changing from Individual to Family Coverage

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

- Your name, date of birth, 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 for any dependent eligible for Medicare

Additional documentation may be required (see *Proof of Eligibility*, page 9).

First date of eligibility

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

The date your dependent's coverage begins will depend on your reason for changing coverage and your timeliness in applying. You can avoid a late enrollment waiting period by applying promptly, even if you are unable to provide the required proofs at that time. (**Note:** Proofs are due 30 days from the date the application is received by your HBA.)

You may change from Individual to Family coverage without the imposition of a late enrollment waiting period as a result of one of the following events:

- You acquire a new dependent (for example, you marry or become a parent). **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:

- **30 days or less after a dependent's first date of eligibility**, your Family coverage will be effective on the date the dependent was first eligible.
- **More than 30 days after a dependent's first date of eligibility**, a late enrollment waiting period will apply. Your Family coverage will become effective on the first day of the third month following the month in which you apply. If you apply on the first day of the month, that month is counted as the first month of the waiting period.

Covering newborns

Your newborn child is not automatically covered; you must contact your HBA to complete the appropriate forms. For additional documentation that may be needed, refer to *Proof of Eligibility*, page 9.

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

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.

Adding a Previously Eligible Dependent to Existing Family Coverage

To add a previously eligible but not yet enrolled dependent to your existing Family coverage, contact your HBA. Your previously eligible dependent's coverage will begin based on the time frames outlined in *First date of eligibility* above.

Changing from Family to Individual Coverage

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

Refer to the section *End Dates for Coverage*, page 20, for information about when your dependent's coverage ends if you change from Family to Individual coverage, or contact your HBA. For information about continuing coverage, see *COBRA: Continuation of Coverage* on page 36 and *Young Adult Option* on page 40, or contact your HBA.

Your Share of the Premium

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

Employees and Dependents

New York State Civil Service Law establishes 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. For NYSHIP HMO coverage, your employer must contribute the same dollar amount they would have paid if you were enrolled in The Empire Plan, but not to exceed the cost of the NYSHIP HMO plan. Your employer may contribute more toward the premium. Ask your HBA 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 HBA for information.

Dependent Survivors

Participating Employers are only required to contribute to the cost of dependent survivor coverage in certain situations. Refer to *Dependent Survivor Coverage* on page 30 and contact your HBA for information.

COBRA Enrollees

Your employer is not obligated to contribute toward the cost of your COBRA premium, and as a COBRA enrollee, you may be responsible for paying both the employer and employee shares of the premium. Refer to *COBRA: Continuation of Coverage*, page 36 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*, page 40 for information.

Identification Cards

Empire Plan Enrollees

Upon enrollment in The Empire Plan, you will receive one or more Empire Plan cards (depending on whether you enroll in Individual or Family coverage). The cards will be sent to the address on your enrollment record. These cards include your name and the names of your covered dependents (refer to page 75 of the *Appendix* for an example of your benefits card). Use these cards as long as you remain enrolled in The Empire Plan. 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 Empire Plan card before you receive services, supplies or prescription drugs.

Your Empire Plan Medicare Rx card

If you or a dependent is enrolled in Empire Plan Medicare Rx, each person enrolled in Empire Plan Medicare Rx will receive a separate card for prescription drugs. Use this card whenever filling a prescription. (See *Empire Plan Medicare Rx card*, page 75.)

Ordering a card

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

If you need to reorder an Empire Plan Medicare Rx card, call the Prescription Drug Program and follow the prompts for Empire Plan Medicare Rx (see *Contact Information*, page 78).

HMO Enrollees

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

Possession of a Card Does Not Guarantee Eligibility

Do not use your card before coverage becomes effective or after eligibility ends. To verify eligibility dates, contact your HBA. 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 yourself or your dependents.

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

How Employment Status Changes May Affect Coverage

Contact your HBA for information about how changes in your employment status can affect your health insurance coverage, the cost of your coverage and how you pay your premium.

Changes that May Affect Coverage

- Leaves of absence, such as:
  - Leave without pay
  - Leave under the Family and Medical Leave Act (FMLA)
  - 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).

Before going on any leave without pay, talk to your HBA about continuing coverage.

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

Family and Medical Leave Act (FMLA)

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

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

Military leave

You may be eligible to continue coverage for yourself and/or your covered dependents while you are on military leave, subject to applicable state and federal laws and executive orders. Consult your HBA 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. See your HBA regarding cost of coverage.

Canceling coverage while on leave

You may cancel your health insurance coverage for the time you are on leave. Your coverage will end on the last day of the month in which your request to cancel your coverage was signed. You may enroll at a later date, usually subject to the late enrollment waiting period (see *First date of eligibility*, page 11). Contact your HBA for more information.

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 *First date of eligibility*, page 11). To request that your coverage be reinstated, contact your HBA.

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 HBA to reactivate your coverage.

Other Changes that Affect Coverage

Change in hours worked

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

- **Reduction in hours:** If your hours are reduced and you are no longer eligible for NYSHIP coverage, your coverage will end on the last day of the month for which coverage was paid. You may be eligible for coverage through COBRA (see page 36).
- **Increase in hours:** If your hours are increased after coverage had been terminated because of a reduction in your hours, contact your HBA to reenroll in NYSHIP coverage.

Termination of employment

If your employment terminates and you are not eligible to continue coverage under the terms outlined in the preceding sections, contact your HBA for the date your coverage will end. When your coverage ends, you will no longer have health insurance coverage through NYSHIP unless you are eligible and elect coverage as a retiree (page 22) or vestee (page 21) or elect COBRA coverage (page 36). You may also be eligible for a direct-pay contract (page 41).

Cancellation for nonpayment of premium

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

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

Eligibility for Preferred List status

You may be eligible to continue coverage for up to one year from the time your employment is terminated if your employer offers Preferred List coverage. You may be required to pay the full cost of coverage, and additional requirements may apply. Contact your HBA for information. As an enrollee with Preferred List status, the second part of this book applies to you (see pages 43-74).

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

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

When your year of Preferred List coverage ends, you may be eligible to continue coverage as a retiree (page 22), vestee (page 21), temporarily under COBRA (page 36) or under a direct-pay conversion contract (page 41).

Enrollment is automatic

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

Waiver of Premium

If you are enrolled in The Empire Plan, you may be entitled to have your health insurance contribution waived for up to one year. To qualify for a waiver of your premium, you must have been totally disabled as a result of sickness or injury on a continuous basis and also meet the following additional criteria:

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

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 made after the date you applied for the waiver.

How to apply for a waiver of premium

To apply for a waiver of premium, obtain the form *Application for Waiver of Empire Plan Premium* (PS-452) from your HBA or access it on NYSHIP Online. Once the application form has been completed, return it 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.

EBD will notify you if your waiver has been granted.

Additional waiver of premium

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

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

- If you return to work for less than three months, you may resume coverage under the previous waiver for the remainder of the original one-year period (including the time back at work)
- If you return to work for three or more consecutive months, you may apply for a new waiver of premium for an additional one-year period

There is no lifetime limit to the number of waivers you may receive. EBD will notify your employer if an additional waiver has been granted.

Waiver ends

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

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

End Dates for Coverage

Note: If you or your dependent is no longer eligible for NYSHIP coverage and the request is made in a timely manner, in certain cases, coverage may be continued under COBRA (see page 36).

You, the Enrollee

Loss of eligibility

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

Suspending coverage

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

Consequences

If you die while your coverage is canceled or suspended, your dependents will have no right to continue coverage as dependent survivors. If you cancel your enrollment while you are in vestee status, you will not be eligible to reenroll in NYSHIP as a vestee unless you have maintained continuous NYSHIP coverage elsewhere.

Dependent Loss of Eligibility

Contact your HBA 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 your dependent children will end on the last day of the month in which the maximum age is reached (for dependent children who lose eligibility due to age) or on the date the dependent otherwise loses eligibility for coverage (for example, for disabled or "other" children). See page 7 for more information about dependent child eligibility.

Spouse

Coverage for your spouse will end on the effective date of the divorce (date filed by the court).

Domestic partner

Coverage for your domestic partner will end on the effective date of the dissolution of the domestic partnership. Submit a completed form *Termination of Domestic Partnership* (PS-425.4) to your HBA.

Vestee Coverage

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

You may continue coverage as:

- An enrollee in vestee coverage with your former employer
- A dependent of a NYSHIP enrollee
- An enrollee in another agency that offers NYSHIP coverage (**Note:** If you attain eligibility for NYSHIP coverage in retirement through a new employer, you will lose your right to your NYSHIP retirement benefits through your previous employer.)

Continuing NYSHIP Coverage as a Vestee with Your Former Employer

Eligibility

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

- Are a member of a class or category of employee for which your employer provides coverage in retirement;
- Have vested as a member of a retirement system administered by the State or one of its political subdivisions (such as a municipality);
- Have met your employer's minimum service requirement (see *Eligibility Requirements for NYSHIP Coverage*, page 23) but are not yet eligible to collect a pension at the time employment is terminated; and
- Are within five years of retirement eligibility (if your agency has adopted this requirement).

If you are a member of the State University of New York Optional Retirement Program with a vendor such as Teachers Insurance and Annuity Association of America (TIAA), and you maintain your eligibility for disbursements upon reaching retirement age, you will maintain vestee coverage until you meet the age requirement of the Employees' Retirement System retirement tier in effect at the time you last entered service.

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

Enrollment

If your employment with a Participating Employer ends, contact your HBA to learn more about vestee coverage. Failure to apply in a timely manner can result in a lapse of coverage resulting in a loss of eligibility to continue coverage.

Cost

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

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

Sick leave credit does not apply

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

Continuing Coverage as a Dependent of NYSHIP Enrollee

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 HBA to begin coverage as an enrollee. 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.

Continuing Coverage Through Another NYSHIP Employer

If you attain eligibility for NYSHIP coverage in retirement through a new employer, you will lose your right to your NYSHIP retirement benefits through your previous employment with a Participating Employer.

Canceling Enrollment

If your NYSHIP vestee coverage is canceled prior to your retirement eligibility, you will not be able to reinstate your NYSHIP vestee coverage and you will not be eligible for NYSHIP retiree coverage.

Eligibility to Continue Coverage When You Retire

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 HBA for specific details about how this applies to you.** The information in this section may be used as a general guideline.

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

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

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

Dental and vision coverage

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

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

Eligibility Requirements for NYSHIP Coverage

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

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

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

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

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

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

2. Complete your employer's minimum service requirement.

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

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

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

Credit for service with other public employers

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

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

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

You must be qualified for retirement as a member of a retirement system administered by New York State (such as the New York State and Local 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 of America (TIAA), you must meet the age requirement of the NYS and Local Retirement System tier in effect at the time you last entered service.

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

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

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

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

Example 1: *Jill is enrolled in NYSHIP coverage offered by her employer, which is a Participating Employer.*

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

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

Disability Retirement

Whether your retirement is considered a service retirement or a disability retirement, you will have the same benefits and will be subject to the same policies if you are eligible to continue coverage as a retiree. 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 HBA 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
- **Work-related (accidental) disability retirement:** For a disability retirement resulting from a work-related illness or injury granted by an approved retirement system, your employer's minimum service requirement is waived

Maintain coverage while your disability retirement is being decided

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

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

Disability retirement award

To request retiree coverage after you receive a disability retirement award, contact your HBA 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.

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 be based on your date of retirement or on the first day of the month following the date of your request

Deadline for reinstating coverage

If retroactive retirement is granted after you discontinued your coverage, write to EBD to reinstate coverage as soon as you receive the decision on your disability retirement. You must provide a copy of the award letter from the retirement system that includes your disability retirement date. You should apply within a year of the date on the letter granting your disability retirement. However, you will be responsible for paying any retroactive premiums you missed while your coverage was canceled (from the date your coverage terminated to the effective date of your retirement, had it been granted in a timely manner).

What You Pay

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

- Contribution rate
- Health insurance option
- Type of coverage (Individual coverage or Family coverage)
- Sick leave credit, if any

EBD will notify you of the monthly amount you must pay.

How You Pay

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

If you are eligible and elect to have your share of the monthly premium deducted from your pension check, it may take several months for EBD to receive the Retirement Number assigned to you by the Retirement System and begin taking monthly deductions. Once your eligibility for retiree benefits has been confirmed by EBD, you will be billed directly each month for your share of the premium until deductions from your pension check begin. Your coverage will remain in effect until your eligibility for retiree benefits has been confirmed, but during that time you may not receive communication from EBD.

Sick Leave Credit

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

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

When you retire, your agency provides EBD with the information necessary to calculate your sick leave credit, if any. The "Dear Retiree" letter from EBD will report this monthly sick leave credit. If you believe this credit is incorrect, contact your HBA. This letter will also include the monthly cost of your coverage in retirement for the option you are currently enrolled in (at the current rate for that option). ***Keep this letter for future reference.***

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

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

Lifetime monthly credit

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

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

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

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

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

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

When sick leave credit ends

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

The Dual Annuitant Sick Leave Credit Option

Prior to your retirement, if you are eligible for sick leave credit and if your employer offers the Dual Annuitant Sick Leave Credit Option, you may elect the Dual Annuitant Sick Leave Credit Option. This election will allow your dependent survivors to continue to use your monthly sick leave credit toward their NYSHIP premium after you die. To enroll, you must choose this option before your last day on the payroll. Confirm that your dependent will qualify for coverage as a dependent survivor before electing this option. (See *Dependent Survivor Coverage*, page 30.)

If you choose the Dual Annuitant Sick Leave Credit Option, you will use 70 percent of your sick leave credit for your premium for as long as you live. This 70 percent monthly credit will continue to be applied to the NYSHIP premium for your eligible dependents who outlive you. If your dependents die before you, you will retain the 70 percent sick leave credit. (Regardless of whether or not you choose the Dual Annuitant Sick Leave Credit Option, your surviving dependents will be eligible to continue coverage after your death if they meet the NYSHIP eligibility requirements outlined in *Dependent Survivor Coverage*, page 30.)

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

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

Spouses who are both eligible for sick leave credit

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

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

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

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

Reactivating Individual enrollment

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

Deferred Health Insurance Coverage

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

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

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

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

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

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

Contact your HBA if you have questions about deferring your coverage.

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

Reenrolling as a Retiree

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

Pre-Retirement Checklist

☐ Contact Your HBA

- ☐ Ask your HBA if your class or category of employment is eligible to continue NYSHIP coverage in retirement. If the answer is yes, ask about the minimum service requirements and read the retirement information in this book to learn more about what you will need to do before you retire. For more information, also read the *PE Planning for Retirement* publication and the *Planning for Retirement Benefits Checklist* for PEs.
- ☐ Meet the minimum service requirements for continuing benefits in retirement, and, at the time you retire, make sure that you are enrolled in NYSHIP or other coverage offered by your employer. For health insurance, be especially sure to check any part-time service or service with another public employer that may count as qualifying service (if needed). Talk with your HBA if you have questions.
- ☐ Ask your HBA 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 HBA 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

- ☐ Enroll in Medicare Parts A and B when first eligible for primary Medicare benefits (see *Medicare and NYSHIP*, page 31). You will be reimbursed by your former employer for the Medicare Part B premium you pay, minus any late enrollment penalty.
- ☐ If you or a dependent is already age 65 or older, three months before you retire call your Social Security Administration office 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 your coverage as a retiree begins.** (Medicare becomes primary to NYSHIP on the first day of the month following your last day of coverage as an active employee.) When you contact Social Security, ask for a "special enrollment period" due to your change in employment status. It is your responsibility to ensure Medicare coverage is in effect at the time your active coverage ends.
- ☐ After you retire, when you or a dependent reaches age 65 and is newly eligible for Medicare, NYSHIP requires you to have Medicare Parts A and B in effect on the first day of the month you reach age 65, or the first day of the previous month if your birthday falls on the first day of the month. Plan to sign up three months before turning 65.
- ☐ After you retire, if you or your dependent is eligible for Medicare for a reason other than age (i.e., disability, end-stage renal disease, ALS), Medicare Parts A and B provide coverage that is primary to NYSHIP (see *Medicare and NYSHIP*, page 31).

☐ If You Are Moving When You Retire

- ☐ Before you retire, notify your HBA of any change to your address and phone number.
- ☐ After you retire, to report address changes or enrollment changes, contact EBD.

Dependent Survivor Coverage

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

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

Note: Survivors of COBRA enrollees are not eligible for the extended benefits period or dependent survivor coverage. Refer to the *COBRA: Continuation of Coverage* section starting on page 36 for information.

Extended Benefits Period at No Cost

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

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

Eligibility for Dependent Survivor Coverage After the Extended Benefits Period Ends

After the extended benefits period ends, enrolled covered dependents may elect to continue NYSHIP coverage if they are eligible for dependent survivor coverage. Refer to *The Empire Plan Certificate for Participating Employers* for benefit information.

Dependent survivors are eligible to continue NYSHIP coverage as individuals in their own right. Eligible dependent survivors may be enrolled in Individual coverage, Family coverage or a combination thereof.

Eligible Dependents

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 remarried or acquired a new domestic partner (if the former employer provides coverage for domestic partners)
- Dependent children who meet the eligibility requirements outlined on page 7 of *Dependent Eligibility*

For dependents 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 the enrollee's death or be a newborn child of the enrollee born after 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. Contact the former employee's HBA for information.

A covered dependent who is not eligible for dependent survivor coverage may be eligible to continue NYSHIP coverage under COBRA (page 36) or may be eligible to convert to a direct-pay contract (page 41).

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 any amount up to the full premium. Check with the former employer's HBA for contribution rates.

Benefit Cards for Dependent Survivors

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

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

Dependent Survivor Eligible for NYSHIP as a Result of Employment

A surviving 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 a Participating Employer or New York State should write to EBD with details of relevant prior employment in order to determine if they are eligible to reinstate coverage as enrollees.

Loss of Eligibility for Dependent Survivor Coverage

A dependent who loses eligibility for dependent survivor coverage may be eligible to continue coverage in NYSHIP under COBRA (see page 36) or convert to a direct-pay contract (see page 41).

Eligibility for dependent survivor coverage ends permanently if a:

- Spouse remarries
- Domestic partner acquires a new domestic partner or marries
- Dependent child no longer meets the eligibility requirements (see page 7)
- 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.

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*, page 37.

Medicare: A Federal Program

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

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

If you have questions about Medicare eligibility, enrollment or cost, contact Social Security at 1-800-772-1213, 24 hours a day, seven days a week. TTY users should call 1-800-325-0778. Or visit 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 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, certain prescription drugs, durable medical equipment and some other services and supplies not covered by Part A.

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

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

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

Medicare and NYSHIP Together Provide Maximum Benefits

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

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

When Medicare Eligibility Begins

You are eligible for Medicare:

- At age 65
- Regardless of age, after being entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
- Regardless of age, after completing Medicare's waiting period of up to three months due to end-stage renal disease (ESRD)
- When receiving SSDI benefits due to amyotrophic lateral sclerosis (ALS)

When NYSHIP Is Primary

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

While NYSHIP is primary, you or your dependent may:

- Enroll in Part A only, to be eligible for some secondary (supplemental) benefits from Medicare for hospital-related services. There is usually no premium for Medicare Part A.
- Delay enrollment in Medicare Parts A or B until Medicare becomes primary. Check with the Social Security Administration regarding enrollment and possible late enrollment penalties.

When Medicare Becomes Primary to NYSHIP

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

- **Domestic partners (if domestic partner coverage is offered by your employer):** Regardless of the enrollee's employment status, Medicare is primary for a domestic partner who is age 65 or older.
- **End-stage renal disease (ESRD):** If you or your dependent is eligible for Medicare due to ESRD, contact the Social Security Administration at the time of diagnosis. Medicare becomes primary to NYSHIP when Medicare's 30-month coordination period is completed.

When you no longer have NYSHIP coverage as the result of active employment (for example, when you are covered as a retiree, vestee, Preferred List enrollee or dependent survivor, or you are covered as the dependent of one of these enrollees) and become eligible for Medicare, Medicare will be primary (an exception applies during the ESRD 30-month coordination period).

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

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

If you or a dependent is required to pay a premium for Medicare Part A coverage, contact your HBA. NYSHIP may continue to provide primary coverage for inpatient hospital expenses and you may delay enrollment in Medicare Part A until you becomes eligible for Part A coverage at no cost.

If your domestic partner is eligible for Medicare due to age (if your employer offers domestic partner coverage) or you or your dependent becomes eligible for Medicare due to ESRD, special rules apply regarding when you must have Medicare Parts A and B in effect. See the rules below for domestic partners. Call your HBA if you or your dependent is diagnosed with ESRD.

Domestic partner eligible for Medicare due to age (65)

When to Apply:

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

Medicare Parts A and B must be in effect on the first day of the month your domestic partner turns 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).

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.

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.

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

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 78) or your HMO.

* ***Exceptions:*** *The benefit payment order differs for domestic partners eligible for Medicare because they are age 65 or older (if your employer offers domestic partner coverage) and certain enrollees or dependents eligible for Medicare due to ESRD.*

Order of Payment for Enrollees with NYSHIP, Medicare and Spouse/Domestic Partner Insurance*			
If Claim Is Incurred By:	**Employment Status**		**Payment Order**
	Enrollee	**Spouse**	
Enrollee	Active	Active	1. NYSHIP 2. Spouse/Domestic Partner Insurance 3. Medicare
Spouse/Domestic Partner**	Active	Active	1. Spouse/Domestic Partner Insurance 2. NYSHIP 3. Medicare
Enrollee or Spouse/Domestic Partner**	Active	Retired	1. NYSHIP 2. Medicare 3. Spouse/Domestic Partner Insurance
Enrollee or Spouse/Domestic Partner	Retired	Active	1. Spouse/Domestic Partner Insurance 2. Medicare 3. NYSHIP
Enrollee	Retired	Retired	1. Medicare 2. NYSHIP 3. Spouse/Domestic Partner Insurance
Spouse/Domestic Partner	Retired	Retired	1. Medicare 2. Spouse/Domestic Partner Insurance 3. NYSHIP

* *If eligibility for Medicare is the result of an ESRD diagnosis, the plan that was primary when Medicare eligibility commenced remains primary during the 30-month coordination period. At the completion of this coordination period, Medicare pays primary.*

** *If a domestic partner of an active NYSHIP enrollee is 65 or older, Medicare will pay before NYSHIP. This does not apply to domestic partners who become eligible for Medicare due to disability and are not yet age 65 or older. This is the only exception for domestic partners; all other order-of-payment rules for spouses apply to domestic partners.*

Order of payment examples

Example 1: *Sarah is employed by a Participating Employer and is covered under NYSHIP. She is over age 65 and is eligible for Medicare coverage, but because she is still working, if Sarah chooses to add Medicare Parts A and B coverage, NYSHIP will still provide her primary coverage, and Medicare will pay secondary. When Sarah receives covered services, NYSHIP should receive claims first, and Medicare second.*

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

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

Additional Information for Medicare-primary Enrollees and Dependents

If you or your dependent is Medicare primary due to ESRD or if your domestic partner is Medicare primary due to age, for additional information refer to the following sections on *Medicare and NYSHIP* in the portion of this book dedicated to retirees:

- *Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan*, page 62
- *Medicare Costs, Payment and Reimbursement of Certain Premiums*, page 63
- *Expenses Incurred Outside the United States*, page 66
- *Provide Notice if Medicare Eligibility Ends*, page 67

Questions

Call your HBA 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

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. There is no employer contribution to the cost of coverage. See *Costs Under COBRA*, page 38.

Benefits Under COBRA

COBRA benefits are the same benefits offered to employees and dependents enrolled in NYSHIP. You must apply for COBRA within 60 days from the date you would lose coverage due to a COBRA-qualifying event or 60 days from the date you are notified of your eligibility for continuation of coverage, whichever is later (see *Deadlines Apply*, page 38). 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 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 22) or vestee (page 21).

Dependents who are qualified beneficiaries

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

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

In no case will any period of continuation coverage last 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
- Termination or reduction in hours of enrollee's employment

- Death of the enrollee
- The COBRA enrollee's enrollment in Medicare

Dependent children

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

- The child's loss of eligibility as a dependent under NYSHIP (e.g., due to age)
- Parents' divorce or termination of domestic partnership
- Termination or reduction in hours of enrollee's employment
- Death of the enrollee
- The COBRA enrollee's enrollment in 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 14, 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 7, and *Coverage: Individual or Family*, page 11). However, a dependent added during a period of COBRA continuation coverage is not considered a qualified beneficiary (with the exception of a newborn or newly adopted child added within 30 days). Dependents who are not qualified beneficiaries may only maintain coverage for the remainder of the enrollee's eligibility for COBRA continuation coverage.

Dependent survivors

- If you were married to a NYSHIP enrollee and are now enrolled in NYSHIP as a dependent survivor, if you remarry, you will not be eligible to continue coverage under COBRA
- If you were the domestic partner of a NYSHIP enrollee and now enrolled in NYSHIP as a dependent survivor, if you remarry or acquire a new domestic partner, you will not be eligible to continue coverage under COBRA (see *Dependent Survivor Coverage*, page 30)

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*, page 33, to learn when NYSHIP requires Medicare coverage to be in effect.

- If you are already covered under COBRA when you are required to enroll in Medicare, your NYSHIP COBRA coverage ends at the point when Medicare enrollment 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*, page 38).
- If you do not enroll in Medicare when first eligible for Medicare-primary coverage, your NYSHIP coverage will be canceled or substantially reduced.
- If you are already covered under Medicare when you elect COBRA coverage, your Medicare coverage will pay first. When enrolled in COBRA, Medicare is your primary coverage.

Choice of Option

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

Deadlines Apply

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

60-day deadline to elect COBRA

When you experience an employment change that affects coverage (for example, termination or reduction in work hours), you must elect continuation coverage within **60 days** from the date of the COBRA-qualifying event or 60 days from the date you are notified of your eligibility for continuation coverage, whichever is later.

Notification of dependent's loss of eligibility

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

- A divorce
- Termination of a domestic partnership
- A child's loss of eligibility as a dependent under NYSHIP (see *Dependent Loss of Eligibility*, page 21)

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

If your HBA 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. EBD 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. Because the 45-day grace period applies to all premiums due for periods of coverage prior to the date of the election, several months' premiums could be due and outstanding. Once you elect COBRA coverage, you will receive a bill for coverage. Ask EBD whether you will receive subsequent payment reminders.

30-day grace period

After the initial 45-day grace period, enrollees will have a 30-day grace period from the premium due date to pay subsequent premiums. Payment is considered made on the date of the payment's postmark.

Continuation of Coverage Period

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

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

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

Survivors of COBRA enrollees

If you die while you are a COBRA enrollee in NYSHIP, your enrolled dependents who are qualified beneficiaries will be eligible to continue COBRA coverage for up to 36 months from the original date of COBRA coverage or may be eligible to convert to a direct-pay contract (see page 41).

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 EBD if you want to cancel your COBRA coverage.

Conversion Rights after COBRA Coverage Ends

At the end of your COBRA coverage period (if you were an Empire Plan enrollee), you may be eligible to convert to a direct-pay conversion contract with the Empire Plan's Medical/Surgical Program administrator (see *Contact Information*, page 78).

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

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

Other Coverage Options

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

Contact Information

If you have any questions about COBRA, but are not currently enrolled, please contact your HBA. If you are enrolled in COBRA, contact EBD.

Young Adult Option

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

Eligibility

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

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

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

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

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

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

Cost

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

Coverage

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

Enrollment Rules

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

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

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

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

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

  If a change of circumstances allows the young adult to meet eligibility requirements for the Young Adult Option, they can enroll 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 EBD 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 HBA.

Direct-Pay Conversion Contracts

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

Eligibility

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

- Termination of employment
- Loss of eligibility for coverage as a dependent
- Death of the enrollee (when the dependent is not eligible to continue coverage as a dependent, as explained in *Dependent Survivor Coverage*, page 30)
- Eligibility for COBRA continuation coverage ends, except when the loss of eligibility is the result of becoming Medicare-eligible due to age

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

- Voluntarily cancel their coverage
- Had coverage canceled for failure to pay the NYSHIP premium
- Have existing coverage that would duplicate the conversion coverage
- Are eligible for Medicare due to age

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

Deadlines Apply

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

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

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

No Notice for Certain Dependents

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

How to Request Direct-Pay Conversion Contracts

To request a direct-pay conversion policy, write to the Empire Plan Medical/Surgical Program administrator (see *Contact Information*, page 78).

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

General Information Book

For Retirees, Vestees and Dependent Survivors of Participating Employers

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

If you are still actively employed by a NYSHIP Participating Employer, including if you are receiving NYSHIP benefits while you are on a leave of absence, refer to the first part of this book, pages 3-42, for information.

When You Need Assistance

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

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

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

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

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

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

When You Must Contact EBD

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

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

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

Your phone number changes.

Your name changes.

You need to correct your enrollment record.

Your family unit changes (see *Dependent Eligibility*, page 50).

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

Your employment status is changing.

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

Your Medicare status is changing.

- You or a covered dependent loses eligibility for Medicare
- You or a covered dependent becomes eligible for Medicare benefits (see *Medicare and NYSHIP*, page 59)

Other reasons to contact EBD.

- 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 68)

Retiree Benefits on the Web

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

Your Options Under NYSHIP

The Options

NYSHIP offers the following options:

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

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

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

For details about The Empire Plan and NYSHIP HMOs, refer to the *Health Insurance Choices* booklet for NY/PE retirees, issued annually, usually in November or December, and contact EBD if you have any questions about your NYSHIP options. If you did not receive a *Health Insurance Choices* booklet by mail in the fall, you may obtain one by visiting our website or contacting EBD.

The Empire Plan or a NYSHIP HMO

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

- Hospitalization and related expense coverage
- Medical/surgical care coverage
- Mental health and substance use treatment coverage
- Prescription drug coverage*

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

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

** Not all Participating Employers provide prescription drug coverage.*

Changing Options

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

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

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

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

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

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

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

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

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

Consider Carefully

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

Retiree Coverage

Eligibility requirements for NYSHIP coverage as a retiree are outlined in the portion of this book for active employees, in *Eligibility to Continue Coverage When You Retire* on page 22.

This part of the book 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 NYSHIP HMO)
- Type of coverage (Individual or Family coverage)

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

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

How You Pay

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

Suspending Enrollment

If you wish to discontinue your enrollment in NYSHIP, contact EBD.

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 EBD. Your dependent may be eligible to continue coverage under COBRA (page 68), the Young Adult Option (page 72) or a direct-pay contract (page 73).

Reinstating Your Coverage as a Retiree

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

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

Dependent* with Independent Eligibility for NYSHIP

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

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

Other Resources

- Talk to EBD. After you retire, EBD will assist you with coverage and enrollment.
- To report certain enrollment changes or address changes, contact EBD.
- Your *Empire Plan Certificate* and annual *At A Glance* booklet provide information about benefits and coverage for Empire Plan enrollees.
- The Department of Civil Service website, www.cs.ny.gov/retirees, has current benefit information. Click on Health Benefits.
- *On the Road with The Empire Plan* is a handy guide to your Empire Plan benefits when traveling.
- Medicare is administered by the Social Security Administration. Call the Social Security Administration at 1-800-772-1213 to enroll in Medicare. For medical benefits and claims information, call 1-800-MEDICARE (1-800-633-4227) or visit the Medicare website, www.medicare.gov.
- The *Medicare & NYSHIP* booklet and companion video explain how NYSHIP and Medicare work together to provide health benefits.
- *Medicare and NYSHIP* on page 59 of this book provides details on NYSHIP coordination of benefits with Medicare. Continue to use this book as a reference for NYSHIP policies after you retire.

Vestee Coverage

For information about eligibility and special rules for continuing NYSHIP coverage as a vestee (when you leave employment with your Participating Employer before you are eligible for coverage as a retiree), see *Vestee Coverage* on page 21 of the portion of this book for active employees.

If you have continued coverage as a vestee, contact EBD 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 When You Retire* on page 22 of the portion of this book for active employees, and contact your former employer with questions.

Dependent Survivor Coverage

Enrolled dependents may be eligible to continue NYSHIP coverage if the enrollee predeceases them.

See the following for dependent eligibility 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 EBD as soon as possible after the enrollee's death. Notification to a retirement system does not satisfy this requirement.

Note: Survivors of COBRA enrollees are not eligible for the extended benefits period or dependent survivor coverage. Refer to the *COBRA: Continuation of Coverage* section starting on page 68 for information on coverage options.

Extended Benefits Period at No Cost

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

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

Eligibility for Dependent Survivor Coverage After the Extended Benefits Period Ends

After the extended benefits period ends, enrolled covered dependents may elect to continue NYSHIP coverage if they are eligible for dependent survivor coverage. Refer to *The Empire Plan Certificate for Participating Employers* for benefit information.

Dependent survivors are eligible to continue NYSHIP coverage as individuals in their own right. Eligible dependent survivors may be enrolled in Individual coverage, Family coverage or a combination thereof.

Eligible Dependents

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 remarried or acquired a new domestic partner (if the former employer provides coverage for domestic partners)
- Dependent children who meet the eligibility requirements outlined on page 50 of *Dependent Eligibility*

For dependents 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 the enrollee's death or be a newborn child of the enrollee born after 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. Contact the former employee's HBA for information.

A covered dependent who is not eligible for dependent survivor coverage may be eligible to continue NYSHIP coverage under COBRA (page 68) or may be eligible to convert to a direct-pay contract (page 73).

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 any amount up to the full premium. Check with the former employer's HBA for contribution rates.

Benefit Cards for Dependent Survivors

After the extended benefits period ends, the primary dependent survivor becomes the enrollee. EBD will change the enrollment file to show the primary dependent survivor as the enrollee. In most cases, this will be the spouse or domestic partner.

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

Dependent Survivor Eligible for NYSHIP as a Result of Employment

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

Loss of Eligibility for Dependent Survivor Coverage

A dependent who loses eligibility for dependent survivor coverage may be eligible to continue coverage in NYSHIP under COBRA (see page 68) or convert to a direct-pay contract (see page 73).

Eligibility for dependent survivor coverage ends permanently if a:

- Spouse remarries
- Domestic partner acquires a new domestic partner or marries
- Dependent child no longer meets the eligibility requirements (see page 51)
- Dependent survivor fails to make the required payments

If NYSHIP coverage as a dependent survivor is terminated for any reason, eligibility ends and the dependent is not eligible to reenroll. If a surviving spouse or domestic partner loses eligibility or dies, eligible dependent children may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents.

Dependent Eligibility

You may cover your eligible dependents under NYSHIP by enrolling in Family coverage or by adding eligible dependents to existing Family coverage. Dependents who meet 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 at any time. To enroll your dependent who is eligible for NYSHIP but not yet enrolled, contact EBD for enrollment information.

See *Proof of Eligibility* on page 52 for required proofs that must be submitted with the request to add a dependent to your coverage. For more information about when coverage will take effect, see page 54.

Note: Enrollees covered under the Young Adult Option are eligible for Individual coverage only; they may not cover any dependents. Refer to *Young Adult Option* on page 72 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 provide coverage.

Your Domestic Partner

Ask EBD if your former employer offers coverage to domestic partners. If your employer does not offer coverage to domestic partners, your domestic partner is not eligible to be covered as your dependent under NYSHIP. Your domestic partner's child(ren) also may not be eligible, unless eligible as "other" children (see page 53). **Eligibility and coverage rules for domestic partners or children of domestic partners in this book apply only if that coverage is offered by your former employer.**

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

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

To enroll a domestic partner, you must complete and return the form *NYSHIP Domestic Partner Enrollment Application* (PS-425) and submit the applicable proofs as outlined in the application to your HBA. 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 your domestic partner's coverage, referred to as imputed income, is considered to be a taxable fringe benefit. The imputed income will increase your taxable gross income for federal and state income taxes, as well as Social Security and Medicare payroll taxes. Check with EBD to find out how imputed income is reported and for an approximation of the fair market value for domestic partner coverage. You may also ask a tax consultant how enrolling a domestic partner will affect your taxes.

Your Children

The following children are eligible for coverage until age 26:

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

Your "other" child

You may cover "other" children:

- Who are financially dependent on you
- Who reside with you

The above requirements must have been reached before the "other" child is age 19. You must file the form, *NYSHIP Statement of Dependence for "Other" Children* (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 they would otherwise have lost eligibility due to age

Contact EBD 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 *NYSHIP Statement of Disability* (PS-451) and provide medical documentation. You will be asked to verify the continued disability — at minimum — every seven years (frequency based on disabling condition) by resubmitting the form and medical documentation. If a disabled dependent is also an "other" child, you will be required to resubmit the form *NYSHIP Statement of Dependence for "Other" Children* (PS-457) every two years (at minimum).

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

For the purposes of eligibility for health insurance coverage as a dependent, you may deduct from your child's age (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:

- Be enrolled in school on a full-time basis
- Be unmarried and
- Not be eligible for other employer group coverage

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

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

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

Proof of Eligibility

Your application to enroll or to add a dependent to your coverage will not be processed by EBD without the required proof of eligibility. Refer to *Retiree Coverage* (page 47), *Vestee Coverage* (page 21), *Dependent Survivor Coverage* (page 48) and *Dependent Eligibility* (page 50) for eligibility requirements.

Required Proofs

You must provide the following proofs to EBD:

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 *NYSHIP Domestic Partner Enrollment Application* (PS-425), with appropriate proof
- 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, *NYSHIP Statement of Disability* (PS-451) with appropriate documentation as required in the application
- Medicare card (if applicable)

"Other" children*

(For more information about who qualifies as an "other" child, please refer to the section *Your Children*, page 51.)

- Birth certificate
- Completed form *NYSHIP Statement of Dependence for "Other" Children* (PS-457) with appropriate documentation as required in the application
- Medicare card (if applicable)

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

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

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

** *Not all employers offer coverage to domestic partners (see* Dependent Eligibility*, page 50). Contact EBD for information.*

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

Coverage: Individual or Family

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

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

Individual Coverage

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

If you do not enroll when first eligible, you may be subject to a late enrollment waiting period. Refer to *First date of eligibility* below for more information.

Family Coverage

Family coverage provides benefits for you and any eligible dependents you elect to enroll. For more information on who can qualify as your dependent, see *Dependent Eligibility*, page 50.

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 NYSHIP Family coverages. If your spouse (or domestic partner, if your former employer offers NYSHIP coverage for domestic partners) enrolls in NYSHIP as an employee of New York State, only one of you may elect Family coverage. The other spouse may only elect Individual coverage.

Changing Coverage

Changing from Individual to Family coverage

If you wish to change from Individual to Family coverage (and your dependent meets the requirements listed in *Dependent Eligibility*, page 50), contact EBD. Be prepared to provide the following:

- Your name, date of birth, Social Security number, address and phone number.
- The effective date and reason you are requesting the change (see the following for more information).
- Your dependent's name, date of birth and Social Security number.
- A copy of the Medicare card, if your dependent is eligible for Medicare. Additional documentation may be required (see *Proof of Eligibility*, page 52).

First date of eligibility

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

The date your dependent's coverage begins will depend on your reason for changing coverage and your timeliness in applying. You can avoid a waiting period by applying promptly, even if you are unable to provide the required proofs at that time. (**Note:** Proofs are due 30 days from the date the application is received by EBD.)

You may change from Individual to Family coverage without the imposition of a late enrollment waiting period as a result of one of the following events:

- You acquire a new dependent (for example, you marry or become a parent). **Note:** The time frame for covering newborns is different (see the following section, *Covering newborns*).
- Your dependent's other health insurance coverage ends.

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

- **30 days or less after a dependent's first date of eligibility**, your Family coverage will be effective on the date the dependent was first eligible.
- **More than 30 days after a dependent's first date of eligibility**, a late enrollment waiting period will apply. Your Family coverage will become effective on the first day of the third month following the month in which you apply. If you apply on the first day of the month, that month is counted as the first month of the waiting period.

Covering newborns

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

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

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

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.

Adding a Previously Eligible Dependent to Existing Family Coverage

To add a previously eligible but not yet enrolled dependent to your existing Family coverage, contact EBD. Your previously eligible dependent's coverage will begin based on the timelines outlined in *First date of eligibility*, on page 54.

Changing from Family to Individual Coverage

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

Refer to the section *End Dates for Coverage*, page 58, for information about when your dependents' coverage ends if you change from Family to Individual coverage, or contact EBD. For information about continuing dependent coverage, see *COBRA: Continuation of Coverage* on page 68 and *Young Adult Option* on page 72, or contact EBD.

No Coverage During Waiting Period

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

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. This is known as the late enrollment period.

A late enrollment waiting period will be waived if your other coverage terminates. You still must enroll within 30 days of losing your other coverage to avoid a late enrollment waiting period.

Exception: Dependent affected by National Medical Support Order

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

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

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

An employee or eligible dependent may enroll in NYSHIP if:

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

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

Canceling Enrollment

To cancel your enrollment in NYSHIP, contact EBD.

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.

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 HBA. Your dependent may be eligible to continue coverage under COBRA (page 68), the Young Adult Option (page 72) or a direct-pay contract (page 73).

Reenrolling dependents

Dependents who lose eligibility can again be covered under NYSHIP if eligibility is restored. For example, unmarried, disabled dependent children who lost eligibility because they were no longer disabled can again be covered under NYSHIP if the same disability that qualified them as disabled dependents while previously enrolled in NYSHIP again renders them incapable of self-support. Appropriate documentation will be required.

Your Share of the Premium

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

What You Pay

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 EBD or directly to your former employer.

Retirees

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

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

- Health insurance option (Empire Plan or NYSHIP HMO)
- Type of coverage (Individual coverage or Family coverage)
- Sick leave credit, if applicable

EBD will notify you of the monthly amount you must pay or advise you of who to contact for this information.

Rate Information

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

Vestees and 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 21, or *Young Adult Option*, page 72, for more information.

Dependent Survivors

Contact EBD for the cost of coverage.

Military Active Duty

If you are a retiree and are a member of an Armed Forces Reserve or a National Guard Unit called to active duty by a declaration of the President of the United States or an Act of Congress, your dependents will be eligible for coverage if you had Family coverage for at least 30 days before your activation. To arrange for this benefit if you are going on active military duty, you or a family member must contact EBD and provide documentation of the dates you were called to active duty. You may be required to pay the full cost of the premium.

Identification Cards

Empire Plan Enrollees

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

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

Present your NYSHIP Empire Plan card before you receive services, supplies or prescription drugs. The nine-digit number on your card is your Empire Plan identification number.

Your Empire Plan Medicare Rx card

If you or a dependent is enrolled in Empire Plan Medicare Rx, each person enrolled in Empire Plan Medicare Rx will receive a separate card for prescription drugs. Use this card whenever filling a prescription. (See *Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan*, page 62.)

Ordering a card

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

If you need to order an Empire Plan Medicare Rx card, call the Prescription Drug Program and follow the prompts for Empire Plan Medicare Rx (see *Contact Information*, page 78).

HMO Enrollees

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

Possession of a Card Does Not Guarantee Eligibility

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

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

End Dates for Coverage

Note: If you or your dependent is no longer eligible for NYSHIP coverage and the request is made in a timely manner, in certain cases, coverage may be continued under COBRA (see page 68).

You, the Enrollee

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 your NYSHIP vestee coverage is canceled prior to your retirement eligibility, you will not be able to reinstate your NYSHIP vestee coverage and you will not be eligible for NYSHIP retiree coverage.

Dependent Loss of Eligibility

Contact EBD 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 your dependent children will end on the last day of the month in which the maximum age is reached (for dependents who lose eligibility due to age) or on the date the dependent otherwise loses eligibility for coverage (for example, disabled children or "other" children). See page 51 for more information about dependent child eligibility.

Spouse

Coverage for your spouse will end on the effective date of the divorce (date filed by the court).

Domestic partner

Coverage for your domestic partner will end on the effective date of the dissolution of the domestic partnership. Submit a completed form *Termination of Domestic Partnership* (PS-425.4) to EBD.

Medicare and NYSHIP

NYSHIP requires enrollees and covered dependents to enroll in Medicare Parts A and B when they are first eligible for Medicare coverage that 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*, page 70.

Medicare: A Federal Program

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

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

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

For questions about Medicare benefits, visit www.medicare.gov or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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, certain prescription drugs, durable medical equipment and some other services and supplies not covered by Part A.

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.

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

Medicare and NYSHIP Together Provide Maximum Benefits

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

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

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

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

Empire Plan enrollees

When Medicare is primary to The Empire Plan for you and/or your covered dependents, The Empire Plan will coordinate hospital, medical and mental health and substance use care benefits with your traditional Medicare Parts A and B coverage. Your prescription drug coverage will be provided under Empire Plan Medicare Rx, a Medicare Part D plan with enhanced benefits.* Refer to *Empire Plan Medicare Rx: A Medicare Part D Prescription Drug Plan* on page 62.

HMO enrollees

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

** Not all Participating Employers provide prescription drug coverage.*

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

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

When Medicare Eligibility Begins

You are eligible for Medicare:

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

When Medicare Becomes Primary to NYSHIP

Medicare becomes primary to NYSHIP when:

- 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**
- You are eligible for Medicare

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

- **End-stage renal disease (ESRD):** If you or your dependent is eligible for Medicare due to ESRD, contact the Social Security Administration at the time of diagnosis
- **Domestic partners (if domestic partnership is offered by your former employer):** Regardless of the employment status of the enrollee, Medicare is primary for a domestic partner age 65 or older

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

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

If you or a dependent is required to pay a premium for Medicare Part A coverage, contact EBD. 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.

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

When to Apply:

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

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

Note: Although Medicare allows you to enroll up to three months after your 65th birthday, NYSHIP requires you to have Medicare Parts A and B in effect when Medicare becomes primary to NYSHIP.

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

When you are Medicare-eligible due to disability

When to Apply:

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

If you or a covered dependent becomes eligible for Medicare due to disability prior to age 65 (refer to *When Medicare Eligibility Begins* on page 61), 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 ESRD, 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 (ESRD)

Special rules apply to people who have been diagnosed with ESRD. Contact the Social Security Administration for Medicare information if you or your dependent is being treated for ESRD or if you expect to receive a kidney transplant.

Once you have been determined to be eligible for Medicare due to ESRD, a 30-month coordination period applies. During this coordination period, NYSHIP remains the primary coverage. (**Exception:** If you are already Medicare primary when the coordination period starts, Medicare continues to be primary.) Upon completion of the coordination period, Medicare becomes primary.

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 at www.ssa.gov.

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

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

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 the 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 the Centers for Medicare & Medicaid Services (CMS). **If you decline Empire Plan Medicare Rx, you will cancel all Empire Plan coverage, including hospital, medical/surgical, mental health and substance use care 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.

** Not all Participating Employers provide prescription drug coverage.*

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. In most cases, you are not required to take any action, contact EBD immediately if:

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

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

Also contact EBD 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 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 use care 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.

Empire Plan Medicare Rx ID card

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

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

Continue to use your Empire Plan benefit card (see *Identification Cards*, page 58) 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 61), 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 premium

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 EBD 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 at www.medicare.gov.

Medicare Part B IRMAA

In addition to the standard premium for Medicare Part B, Medicare enrollees with a higher modified adjusted gross income (MAGI) pay an additional income-related monthly adjustment amount (IRMAA), a Medicare premium amount adjusted for their income, for Part B coverage. If you are required to pay a Medicare Part B IRMAA, that amount will be included in your annual Social Security award letter. If eligible, your former employer will reimburse you for this amount. See *Medicare Part B IRMAA reimbursement* on page 65.

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

How you pay

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

- Deductions from your Social Security checks
- Deductions from your Railroad Retirement Board pension
- Direct payments to the Social Security Administration

Medicare Part B premium reimbursement

When you or your dependent is required to enroll in Medicare (as described in *When You are Required to Have Medicare Parts A and B in Effect* on page 61), NYSHIP will reimburse you the Medicare Part B premium and Medicare Part B IRMAA. You are not entitled to a reimbursement if:

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

You are required to notify EBD if either of the above circumstances applies to you.

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

If you or your dependent is required to enroll in Medicare due to age or disability, contact EBD to apply for reimbursement.

Standard Medicare Part B premium reimbursement

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

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

Medicare Part B IRMAA reimbursement

Contact EBD to apply for Medicare Part B IRMAA reimbursement. You will be required to provide:

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

Medicare Part D

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

Your Claims When Medicare Is Primary

When Medicare and NYSHIP are your only coverage

Benefits are paid in the following order:

1. Medicare

2. NYSHIP (Empire Plan or HMO)

If you have questions about claims coordination with Medicare, contact the appropriate Empire Plan program administrator (see *Contact Information*, page 78) or contact your HMO.

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

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

Example 2: *Matt is actively employed but does not have health insurance through his employer. Matt's wife Sarah is a retiree and has NYSHIP retiree coverage through her former employer. Matt is a dependent on Sarah's NYSHIP coverage. Matt is still working when he becomes eligible for Medicare. However, Medicare becomes primary to NYSHIP because Sarah's NYSHIP coverage is retiree coverage. Claims are submitted to Medicare first, then to Sarah's NYSHIP coverage.*

Example 3: *Marie is a retiree and has NYSHIP retiree coverage through her former employer. Marie's husband, Jose, is a retiree from a different employer, and also has retiree coverage through NYSHIP. Jose has Family coverage and covers Marie as his dependent. In addition, Marie is eligible for Medicare because she receives SSDI benefits due to amyotrophic lateral sclerosis (ALS). When Marie is admitted into the hospital, claims are submitted to Medicare first, then to the NYSHIP coverage she has as a retiree, then to the NYSHIP coverage she has as a dependent of Jose, also a retiree.*

Example 4: *Will is over age 65 and is a retiree of a Participating Employer. Will's wife, Susan, is still actively working with an employer that provides NYSHIP coverage. Will is covered as a dependent on Susan's active coverage. When Will receives covered services, claims are first submitted to Susan's active NYSHIP coverage, then to Medicare, then to Will's retiree NYSHIP coverage last.*

When you have coverage in addition to Medicare and NYSHIP

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

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

Expenses Incurred Outside the United States

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

Traveling outside the United States

Empire Plan enrollees

For covered services received outside the United States, file claims directly with The Empire Plan (see *Contact Information*, page 78). For more information, refer to your *Empire Plan Certificate* and the publication *On The Road with The Empire Plan*.

NYSHIP HMO enrollees

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

Residing outside the United States

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

If your permanent residence is outside the United States, enrollment in Medicare is not required by NYSHIP.* However, if you choose to enroll in Medicare or remain enrolled in Medicare, your former employer will reimburse your Medicare Part B premium.

If you return temporarily to the United States for medical treatment and you maintained enrollment in Medicare, Medicare will be primary. Contact EBD for information on Medicare premium reimbursement. If you did not maintain enrollment in Medicare, contact EBD.

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

* ***Note:*** *If you do not enroll or choose to disenroll from Medicare while residing outside the United States, you will be assessed a late enrollment penalty by the Social Security Administration if you enroll in Medicare at a later date (refer to* When You are Required to Have Medicare Parts A and B in Effect*, on page 61).*

Returning permanently to the United States

If you permanently move back to the United States and you maintained Medicare Part B coverage, notify EBD of your new address.

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

- Contact the Social Security Administration for information about how and when you can establish Medicare coverage. If Medicare coverage will not be in effect at the time you return to the United States, contact EBD.
- Contact EBD when you return and provide your new address and a copy of your current Medicare card. Ask EBD 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 EBD.

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 EBD if you have questions about:

- NYSHIP requirements, including when you must enroll in Medicare
- Medicare Part B 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

Please review the three reemployment situations described below and refer to the scenario that best describes you and your intended reemployment situation.

With the Employer You Retired From

If you are returning to work in a benefits-eligible position with the employer that provides your NYSHIP retiree benefits, your status with NYSHIP and Medicare may be affected. Before you are reemployed, talk to the HBA from your former agency about the following:

Choosing active or retiree coverage: If you are eligible for NYSHIP as both an active employee and as a retiree, you must choose one; you cannot have coverage as both an active employee and a retiree (see *Coverage: Individual or Family*, page 54).

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 Another 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 HBAs 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 HBAs at both employers; the cost of coverage may be different at each employer.

Medicare: Your Medicare status will be affected differently depending on whether you choose to enroll in coverage as an employee or continue enrollment as a retiree.

- If you choose to maintain your NYSHIP retiree coverage, Medicare will continue to be primary to NYSHIP after you are employed. NYSHIP will continue to be responsible for reimbursing the Medicare Part B premium to you.
- If you choose to enroll in NYSHIP as an employee, NYSHIP will be your primary coverage while you are working in a benefits-eligible position with that employer. If you were Medicare primary prior to reemployment, this change may affect your premium and coverage, and you will no longer receive any Medicare reimbursement.

With a Non-NYSHIP Employer

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

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. There is no employer contribution to the cost of coverage. See *Costs Under COBRA*, page 71.

Benefits Under COBRA

COBRA benefits are the same benefits offered to retirees and dependents enrolled in NYSHIP. You must elect COBRA coverage within 60 days from the date you would lose coverage due to a COBRA-qualifying event or 60 days from the date you are notified of your eligibility for continuation of coverage, whichever is later (see *Deadlines Apply*, page 70). Documentation of the COBRA-qualifying event may be required.

Eligibility

Enrollee

If you are a NYSHIP enrollee who is no longer covered through active employment, you have the right to COBRA coverage if the one-year coverage allowed/provided under Preferred List provisions is exhausted.
Note: You may be eligible to continue coverage as a retiree (see page 47) or vestee (see page 21).

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 last more 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 as a qualified beneficiary if coverage under NYSHIP is lost as a result of:

- Divorce
- Termination of domestic partnership
- Death of the enrollee
- The COBRA enrollee's eligibility for Medicare

Dependent children

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

- The child's loss of eligibility as a dependent under NYSHIP (e.g. due to age)
- Parents' divorce or termination of domestic partnership
- Death of the enrollee
- The COBRA enrollee's eligibility for Medicare

A COBRA enrollee's newborn child or a child placed for adoption with a COBRA enrollee is considered a qualified beneficiary if coverage for the child is requested within 30 days (see *Covering newborns*, page 55, 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 50, and *Coverage: Individual or Family*, page 54). However, a dependent added during a period of COBRA continuation coverage is not considered a qualified beneficiary (with the exception of children born to or place for adoption with the enrollee during a period of COBRA coverage and added within 30 days. The COBRA 36-month period for such a child is measured from the same

date as for other qualified beneficiaries with respect to the same qualifying event and not from the date of the birth or adoption). 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 you were married to a NYSHIP enrollee and are now enrolled in NYSHIP as a dependent survivor, if you remarry, you will not be eligible to continue coverage under COBRA
- If you were the domestic partner of a NYSHIP enrollee and are now enrolled in NYSHIP as a dependent survivor, if you remarry or acquire a new domestic partner, you will not be eligible to continue coverage under COBRA (see *Dependent Survivor Coverage*, page 48)

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*, page 61, 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 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*, page 71).
- 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 coverage, Medicare is your primary coverage.

Choice of Option

An enrollee or dependent who continues coverage under COBRA will continue to be covered under the same option. COBRA enrollees may change to a different option once during a 12-month period (see *Your Options Under NYSHIP*, page 45) or when moving under the circumstances described in *Qualifying Events: Changing Options More Than Once During a 12-month Period*, page 46. Dependents of a COBRA enrollee who are qualified beneficiaries may also change to Individual coverage once during a 12-month period.

Deadlines Apply

60-day deadline to elect COBRA

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

Notification of dependent's loss of eligibility

To be eligible for COBRA coverage, the enrollee or covered dependent must notify EBD 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 Eligibility*, page 50)

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

If EBD 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. EBD 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. EBD will send bills monthly.

30-day grace period

After the initial 45-day grace period, enrollees will have a 30-day grace period from the premium due date to pay subsequent premiums. Payment is considered made on the date of the payment's postmark.

Continuation of Coverage Period

You and your eligible dependents may have the opportunity to continue coverage under COBRA for up to 36 months. If you, the enrollee, 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 73).

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 EBD 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 78).

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

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

Other Coverage Options

There may be other coverage options available to you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, deductibles and out-of-pocket costs will be before you enroll. Eligibility 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 EBD.

Young Adult Option

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

Eligibility

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

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

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

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

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

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

Cost

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

Coverage

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

Enrollment Rules

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

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

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

  If the young adult no longer qualifies as a parent's NYSHIP dependent due to age, they 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 them to meet eligibility requirements for the Young Adult Option, they can enroll in the Young Adult Option within 60 days of newly qualifying. Examples of a change of circumstances include a young adult's loss of employer coverage or the young adult's divorce.

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

  Coverage may be elected during the Young Adult Option annual 30-day open enrollment period. Contact EBD 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 EBD.

Direct-Pay Conversion Contracts

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

Eligibility

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

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

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

- Voluntarily cancel their coverage
- Had coverage canceled for failure to pay the NYSHIP premium

- Have existing coverage that would duplicate the conversion coverage
- Are eligible for Medicare due to age

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

Deadlines Apply

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

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

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

No Notice for Certain Dependents

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

How to Request Direct-Pay Conversion Contracts

To request a direct-pay conversion policy, write to the Empire Plan Medical/Surgical Program administrator (see *Contact Information*, page 78).

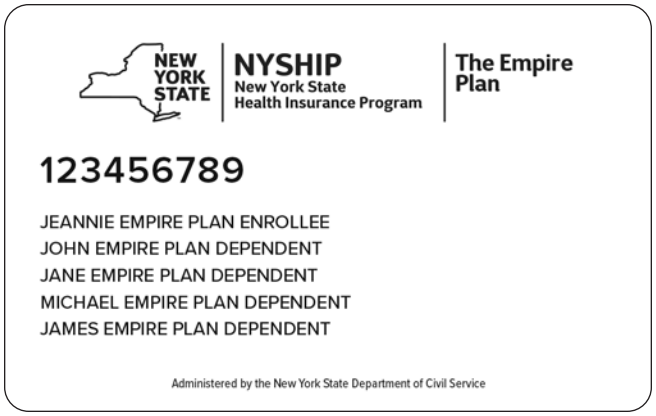
If you were enrolled in an HMO, contact that HMO for more information.

Appendix

Empire Plan Cards

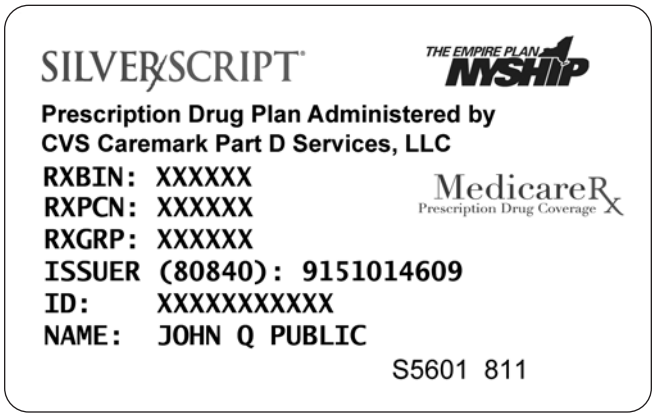
Empire Plan benefit card

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



Empire Plan Medicare Rx card

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



NYSHIP Option Transfer Request

Retirees, submit this form to the Employee Benefits Division to request a change from one NYSHIP option to another.

Enrollee Name _____

Social Security Number (SSN) _____

Mailing Address _____

County _____ City or Post Office _____

State _____ ZIP Code _____ Telephone Number (_____) _____

Is this a new address? ❑ Yes ❑ No Date of New Address _____

Residential Street Address (if different) _____

County _____ City or Post Office _____

State _____ ZIP Code _____

Medicare ❑ Yes ❑ No If Yes, Effective Dates: Part A _____ Part B _____

Dependent Medicare ❑ Yes ❑ No If Yes, Effective Dates: Part A _____ Part B _____

Are you or your dependent reimbursed from another source for Part B coverage? ❑ Yes ❑ No

If Yes, by whom? _____ Amount $_____

Effective _____ 1, 20_____, please change my health insurance option
(month) (year)

From: Current Option Code Number _____ Current Plan Name _____

To: New Option Code Number _____ New Plan Name _____

Date _____ Enrollee Signature *(required)* _____

If you have Family coverage, please complete the following for each dependent enrolled in Medicare *(attach a separate sheet of paper if necessary):*

Dependent Name _____ SSN _____

Medicare ID # *(on his or her Medicare card)* _____ Date _____

Dependent Signature *(required)* _____

Dependent Name _____ SSN _____

Medicare ID # *(on his or her Medicare card)* _____ Date _____

Dependent Signature *(required)* _____

❑ I have no Medicare-eligible dependents

If you are enrolling in an HMO, is the HMO approved by NYSHIP to serve your county?
Please check the *NYSHIP Options by County* guide.

No action is required if you wish to keep your current health insurance.

USE THIS FORM FOR OPTION CHANGE ONLY

NYSHIP Medicare Advantage HMO Disenrollment Form

If you are enrolled in a NYSHIP HMO Medicare Advantage plan, submit this form to the Employee Benefits Division along with the NYSHIP Option Transfer Request form to request a change from one option to another.

Effective _____ **, please cancel my enrollment in:**
Enter date here (must be the first of a month)

Option Code Number _____ Plan Name_____

Social Security Number _____

Member's Name _____
First Middle Last

Address _____

_____

Telephone Number (_____)_____

Medicare Number (As it appears on your Medicare Card)_____

Date _____ Enrollee's Signature _____

Please provide the following required information for each enrolled dependent.

(Attach an additional 8½" x 11" sheet of paper, if necessary).

Dependent's Name _____

Dependent's Social Security Number _____

Dependent's Medicare Number (if applicable) _____

Dependent's Signature _____

Dependent's Name _____

Dependent's Social Security Number _____

Dependent's Medicare Number (if applicable) _____

Dependent's Signature _____

Important: Complete and mail this form to the HMO you are leaving as early as possible prior to the effective date you are requesting. Termination of coverage with this HMO must be coordinated with your new option. You will not be able to receive coverage for medical care from your new option until after the effective date of disenrollment.

No action is required if you wish to keep your current health insurance.

USE THIS FORM FOR OPTION CHANGE ONLY

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 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 OR SAY 2 Hospital Program

Administered by Empire BlueCross

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 OR SAY 3 Mental Health and Substance Abuse Program

Administered by Beacon Health Options

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

TTY: 1-855-643-1476

P.O. Box 1850
Hicksville, NY 11802

PRESS OR SAY 4 Prescription Drug Program

Administered by CVS Caremark

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

TTY: 711

Customer Care Correspondence
P.O. Box 6590
Lee's Summit, MO 64064-6590

NYSHIP HMOs

NYSHIP HMO contact information, including phone numbers, TTY numbers, addresses and websites are available in the *Choices* booklet and on the Department of Civil Service website at www.cs.ny.gov.

Other Agencies and Programs

New York State and Local Retirement System 518-474-7736

Teachers Insurance and Annuity Association of America (TIAA) 518-786-5900

New York State and Local Police and Fire Retirement System 518-474-7736

Medicare 1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

Social Security Administration 1-800-772-1213
TTY: 1-800-325-0778

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

Address Service Requested

Please do not send mail or correspondence to the return address above. See address information on page 78.

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

PE Active and Retiree/General Information Book – 2020

SAVE THIS BOOK

Important information about the New York State Health Insurance Program (NYSHIP)

This book replaces your *2016 General Information Book*. Please keep this book with your Plan materials.

Updates to this book will be mailed to you and will also be posted on our website, https://www.cs.ny.gov. Keep all updates with this book.

NEW YORK STATE | NYSHIP New York State Health Insurance Program

Reasonable accommodation: It is the policy of the New York State Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. If you need an auxiliary aid or service to make benefits information available to you, please contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cs.ny.gov or call 1-877-7-NYSHIP (1-877-769-7447). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-7-NYSHIP (1-877-769-7447) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,250** (**$625** for enrollees in positions at or equated to Grade 6 or below or earning less than $38,651 for UUP) per enrollee, per spouse/domestic partner, and per all dependent children combined. The **deductible** only applies when you seek out-of-network services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use that are not provided at a network facility or by a participating provider. The **deductible** renews each year. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. The **deductible** does not apply to care rendered at a network facility or by a participating provider, preventive care services as defined by the federal Patient Protection and Affordable Care Act (PPACA), hearing aids, prosthetic wigs, modified solid food products, second opinion for cancer diagnosis, external mastectomy prostheses, emergency services, emergency ambulance services, services under the Managed Physical Medicine Program, or prescription drugs.	Most services rendered by a participating provider or at a network facility require only a copayment and do not count toward the Basic Medical Program **deductible**. The **deductible** only applies when you receive out-of-network services.
Are there other deductibles for specific services?	Yes. **$250** per enrollee, per spouse/domestic partner, and per all dependent children combined for non-network Managed Physical Medicine Program. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network Max: Individual **$8,150**/Family **$16,300**. Out-of-Network Coinsurance Max: **$3,750** (**$1,875** for enrollees in positions at or equated to Grade 6 or below or earning less than $38,651 for UUP) per enrollee, per spouse/domestic partner, and per all dependent children combined.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan does not cover do not count toward either **out-of-pocket limit**. In-Network Max excludes non-network expenses and ancillary charges. Out-of-Network Coinsurance Max excludes facility copayments, penalties, and expenses incurred under the Prescription Drug Program, Managed Physical Medicine Program services or Home Care Advocacy Program (HCAP).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cs.ny.gov/employee-benefits **or call 1-877-7-NYSHIP** and choose the appropriate program for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting below for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	20% coinsurance	An additional $25 copayment for radiology, lab services, and/or certain immunizations may apply.
	Specialist visit	$25 copayment/visit	20% coinsurance	
	Preventive care/screening/ immunization	No charge	Most services not covered	Certain services are covered when rendered by a non-participating provider, including well-care services for children.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copayment/office visit; $50 ($40 for NYS CSEA and UCS) copayment/hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	——————none——————
	Imaging (CT/PET scans, MRIs)	$25 copayment/office visit; $50 ($40 for NYS CSEA and UCS) copayment/hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Precertification required if not an emergency or an inpatient procedure. If not precertified, the cost will be greater. The test or procedure is not covered if determined not to be medically necessary.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cs.ny.gov	Level 1 or for most Generic Drugs	$5 for 1-30 day supply; $10 for 31-90 day supply from a Network Pharmacy; $5 for 31-90 day supply from a Mail Service or Specialty Pharmacy	Claims for your out-of-pocket costs may be eligible for partial reimbursement.	Certain medications require prior authorization for coverage. Copayment waived at a network pharmacy for: • Oral chemotherapy drugs when used to treat cancer, Tamoxifen and Raloxifene when prescribed for the primary prevention of breast cancer • Generic oral contraceptive drugs/devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices) • Adult immunizations and certain prescription drugs and over-the-counter medications that are considered preventive under the Patient Protection and Affordable Care Act (PPACA). To learn more, go to www.hhs.gov/healthcare/rights/preventive-care There is an ancillary charge for covered brand-name drugs that have a generic equivalent in addition to the Level 3 copayment.
	Level 2, Preferred Drugs or Compound Drugs	$30 for 1-30 day supply; $60 for 31-90 day supply from a Network Pharmacy; $55 for 31-90 day supply from a Mail Service or Specialty Pharmacy		
	Level 3 or Non-preferred Drugs	$60 for 1-30 day supply; $120 for 31-90 day supply from a Network Pharmacy; $110 for 31-90 day supply from a Mail Service or Specialty Pharmacy		
	Specialty drugs	Applicable copayment based on the drug copayment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copayment/office surgery; $50 copayment/non-hospital outpatient surgery; $95 ($75 for NYS CSEA and UCS) copayment/outpatient hospital surgery	20% coinsurance in an office setting; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
	Physician/surgeon fees	$25 copayment/surgery	20% coinsurance in an office setting	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 ($90 for NYS CSEA and UCS) copayment/visit	$100 ($90 for NYS CSEA and UCS) copayment/visit	Copayment waived if admitted as inpatient directly from the Emergency Department.
	Emergency medical transportation	$70 copayment/trip	$70 copayment/trip	Not subject to deductible or coinsurance.
	Urgent care	$30 copayment/office visit; $50 ($40 for NYS CSEA and UCS) copayment/visit to a hospital-owned urgent care center	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for a hospital-owned urgent care center	An additional $25 copayment for radiology, lab services, and/or certain immunizations may apply. An additional $50 ($40 for NYS CSEA and UCS) copayment for diagnostic radiology and diagnostic laboratory tests in a hospital-owned urgent care center.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	Precertification required; $200 penalty if hospitalization is not precertified.
	Physician/surgeon fees	No charge	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit	20% coinsurance	Pre-certification is required for some mental health care and substance use care.
	Inpatient services	No charge	10% coinsurance	
If you are pregnant	Office visits	No charge for routine prenatal and postnatal care	20% coinsurance	————————none————————
	Childbirth/delivery professional services	No charge	20% coinsurance	————————none————————
	Childbirth/delivery facility services	No charge	10% coinsurance	Precertification required; $200 penalty if hospitalization is not precertified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Precertification required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing.
	Rehabilitation services	$25 copayment/visit	50% coinsurance for office visits under Managed Physical Medicine Program; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.
	Habilitation services	$25 copayment/visit	50% coinsurance	Home Care Advocacy Program (HCAP) or Managed Physical Medicine Program network allowance depending on the service. No charge when precertified if service is covered under HCAP. No coinsurance maximum for Managed Physical Medicine Program or HCAP services.
	Skilled nursing care	No charge	50% coinsurance; 10% coinsurance in a skilled nursing facility	Limitations and exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission is not precertified. Non-network benefits apply if skilled nursing at home is not precertified. No non-network coverage for the first 48 hours. No coverage for Medicare-primary enrollees.
	Durable medical equipment	No charge	50% coinsurance	Diabetic shoes are covered up to $500/year when precertified. Allowance for diabetic shoes purchased at a non-network provider is up to 75% of the network allowance for one pair. Precertification required; non-network benefits apply if not precertified.
	Hospice services	No charge	Inpatient: 10% coinsurance; Outpatient: 10% coinsurance or $75, whichever is greater	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	——————none——————
	Children's glasses	Not covered	Not covered	——————none——————
	Children's dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery[1]
- Custodial care
- Dental care (adult & child), except for the correction of damage caused by an accident
- Long-term care
- Routine eye care (adult & child)
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

[1] With the exception of a diagnosis of gender dysphoria and determination of medical necessity

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery (with limitations)
- Chiropractic care
- Hearing aids (with limitations)
- Infertility treatment (with limitations)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (covered under HCAP only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or www.cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate program
- The New York State Department of Civil Service, Employee Benefits Division at 518-457-5754 or 1-800-833-4344
- The New York State Department of Financial Services at 518-474-6600 or 1-800-342-3736
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates at 888-614-5400 or www.communityhealthadvocates.org

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-769-7447.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$0
Other copayment	$25

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$0
Other copayment	$25

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$90
Other copayment	$25

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

The plan would be responsible for the other costs of these EXAMPLE covered services.