NEW YORK STATE Corrections and Community Supervision **DIRECTIVE**	TITLE **Employee Health Insurance**		NO. 2221 DATE 09/14/2020
SUPERSEDES DIR #2221 Dtd. 12/04/19	DISTRIBUTION A	PAGES PAGE 1 OF 4	DATE LAST REVISED
REFERENCES (Include but are not limited to) Consolidated Omnibus Budget Reconciliation Act (COBRA)	APPROVING AUTHORITY		

I. SCOPE: The New York State Health Insurance Program (NYSHIP) provides employees and their dependents protection against the financial costs of illness. Participation in NYSHIP is voluntary, and the cost of insurance coverage is shared by the State and the employee. Deductions are made directly from the employee's paycheck.

II. DESCRIPTION

A. Options Available to Employees:

- Empire Plan (Statewide Plan)
- Various Health Maintenance Organizations (HMO) that have been approved for participation in NYSHIP in the geographic area where the employee lives or works
- Opt-Out Program: The provisions of the program are outlined in the "Health Insurance Choices Booklet," which is updated yearly for the Option Transfer Period in November/December and is available in the Personnel Office

B. Coverage

1. Employee Eligibility: An employee must be appointed or elected to a position in State service, and:
   a. Be expected to work at least six continuous biweekly payroll periods;
   b. Work at least a half-time regular schedule;
   c. Be on the payroll at the time of enrollment; and
   d. Not already be enrolled in NYSHIP as an employee of New York State, a participating employer, or a participating agency; however, the employee is eligible for individual coverage if they are covered under the program as a dependent of another New York State employee.
2. Effective Date of Coverage: Council 82 and CSEA employees are eligible after 42 days of service; Management/Confidential, PEF, and NYSCOPBA employees are eligible after 56 days of service.

III. DEPENDENT COVERAGE

A. The employee's legal spouse or domestic partner (if they meet State requirements) is eligible.

B. An employee's child, up to 26 years of age, is eligible for medical coverage. This includes natural children, legally adopted children (including children in the waiting period prior to finalization of adoption), dependent stepchildren, and children of a domestic partner. Other children who either reside permanently in the employee's household, are financially dependent on the employee, or for whom the employee has legal responsibility in place of the parent, are also eligible.

The employee's disabled child, who is more than 26 years of age, is eligible if they are:

1. unmarried;
2. incapable of self-support by reason of mental or physical disability; and
3. Acquired the disabling condition prior to when they would have otherwise lost eligibility due to age.

An employee's child who is a full-time student with previous military service may be eligible. Please contact your Health Benefits Administrator (HBA) for eligibility criteria.

Young adults aged 26 through 29 may be eligible for coverage through a parent's group health insurance policy under a "Young Adult Option." For more information about the Young Adult Option, go to: www.cs.ny.gov/yao. This site is the best resource for information on NYSHIP's Young Adult Option. If you have additional questions, please contact the Employee Benefits Division at: 518-457-5754 or 1-800-833-4344.

C. The effective date of dependent coverage is the same as for the employee.

IV. CHANGES, TERMINATIONS, AND CONVERSIONS

A. Changes in Pre-Tax Option: Employees participating in the Pre-Tax Contribution Program may opt out of the program or make arbitrary changes to health insurance coverage not otherwise permitted under the Pre-Tax Contribution Program, only during the Option Transfer Period.

B. Changes in Health Insurance Options: Employees may change their health insurance option for any reason during the annual Option Transfer Period, usually in November/December. Employees will be notified of the Option Transfer Period dates through a mailing from the New York State Department of Civil Service.

C. Changes Between Individual and Family Coverage: Changes should be made within 30 days of a change in an employee's personal status (marriage, divorce, or adding/deleting dependents). To change coverage due to a newborn child, an employee has 30 days from the date of birth. This ensures a prompt change in coverage without a waiting period. The form for requesting coverage changes is available from the HBA or online at: www.cs.ny.gov/forms/ps404.pdf.

D. Change in Departments: When an employee changes agency, his or her health insurance continues automatically.

E. Change in Name or Address: Any name or address change should be reported immediately to the Personnel Office to ensure all records are changed in a timely manner.

F. Termination of Coverage: An employee may terminate coverage at any time, if not enrolled in the Pre-Tax Contribution Program.

G. Leave Without Pay (LWOP): An employee on authorized leave without pay, or otherwise off the State payroll temporarily, may be eligible to continue health insurance while off the payroll. Coverage when on leave without pay is automatic unless the employee contacts the Agency HBA and requests to cancel coverage. A bill will be sent to the employee by the NYS Department of Civil Service's Employee Benefits Division and the employee will be responsible for both the employer's and employee's share of the premiums.

H. Family and Medical Leave (FMLA): If an employee is absent and on FMLA without pay, he or she will only be required to pay the employee share of the premium. A bill will be sent to the employee by the Department of Civil Service's Employee Benefits Division.

I. Preferred List Status: An employee who is separated from State service and whose name has been placed on a Civil Service Preferred List may continue coverage (by paying the employee's share of the premium) for up to one year or until he or she is re-employed on a full-time basis in a benefits-eligible position by a public or private employer, which ever occurs first.

J. Retirement: An employee who retires from State service may continue health insurance coverage. To qualify, the employee must meet the conditions specified in 1, 2, and 3 below:

1. Complete the minimum service period, which is determined by the date the employee entered State service:
    a. If last hired before April 1, 1975, the employee must have had at least five years of benefits-eligible State service, or at least five years of combined service with the State and one or more participating employers or participating agencies.
    b. If last hired on or after April 1, 1975, the employee must have had at least ten years of benefits-eligible State service, or at least ten years of combined service with the State and one or more participating employers or participating agencies.
2. Be qualified for retirement as a member of a retirement system administered by New York State or any of New York State's political subdivisions. If the employee is not a member of a retirement system administered by the State, he or she must satisfy one of the following conditions:
    a. Meet the age requirement of the Employees Retirement System's retirement tier in effect at the time he or she last entered service; OR
    b. Be qualified to receive Social Security disability payments.
3. Be enrolled in NYSHIP as an enrollee or a dependent at the time of retirement.

K. Retirement - Sick Leave Credits: A maximum of 200 days of sick leave credits can be applied to defray the cost of health insurance at retirement. The enrollee has a choice of the Single-Annuitant Option or the Dual-Annuitant Option. If the Single-Annuitant Option is chosen, the enrollee would use 100% of the sick leave credits, and upon death would leave no credits for his or her eligible dependent survivors to use to defray the cost of the health insurance premium.

If the enrollee chooses the Dual-Annuitant Option, the enrollee will use 70% of the sick leave credit toward his or her premium for as long as the employee lives. Eligible dependents who outlive the enrollee will continue to use 70% of the enrollee's monthly sick leave credit to defray the health insurance premium.

Enrollees may defer their health insurance coverage and calculation of sick leave credits indefinitely, provided they have other employer sponsored health insurance coverage. The advantage to deferring coverage is that the enrollee does not have to pay an insurance premium during the period deferred. In order to defer coverage, the enrollee must be enrolled in an employer-sponsored health insurance at the time of retirement and must provide proof of said coverage.

L. Continuation of Coverage Upon Separation

1. If employment with the State ends before the employee reaches retirement age and the employee has vested status, he or she may continue health insurance coverage while in vested status provided the employee pays both the employer and employee shares of the health insurance premium. In no case may sick leave credits be applied toward health insurance premium costs while the employee is in vested status or after the employee becomes eligible to retire. Coverage ends permanently if the employee fails to pay the required premiums. The employee will receive correspondence from the Department of Civil Service detailing this opportunity.
2. Federal legislation, called the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires employers to provide an opportunity for continued coverage for up to 36 months to employees and their dependents who otherwise would have lost their coverage due to the employee's termination of employment. The employee should see his or her HBA for additional information on this. The cost of COBRA coverage is 102% of the gross premium. Payments are made on a monthly basis. The employee and/or dependent has a deadline of 60 days from the date coverage ends to elect COBRA coverage.

V. PROCESSING CLAIMS

A. Empire Plan: If participating providers are used, no additional claim forms are needed. If an employee uses nonparticipating providers, he or she may obtain proper claim forms from the Personnel Office to submit to United Health Care for 80% reimbursement of all reasonable and customary charges, provided a deductible is met.

B. HMOs: No claim forms are required. Claims are handled directly between the HMO and the provider.