

**City of New York
Health Benefits Program
Frequently Asked Questions
for Retirees**

UPON YOUR RETIREMENT YOU WILL BE ENROLLED FOR HEALTH BENEFITS ON THE FIRST DAY OF YOUR RETIREMENT PROVIDED YOUR APPLICATION HAS BEEN PROCESSED BY THE HEALTH BENEFITS PROGRAM PRIOR TO THE DATE OF RETIREMENT (AT LEAST 3 WEEKS BEFORE YOUR RETIREMENT DATE). Make sure that you read the information below to ensure there is no break in your health plan coverage.

PRE-RETIREMENT PROCESS:

1. What are the requirements for eligibility for health benefits at retirement?

a. You have at least ten (10) years of credited service as a member of a retirement or pension system maintained by the City (if you were an employee of the City on or before December 27, 2001, then you must have at least five (5) years of credited service as a member of a retirement or pension system maintained by the City);

OR

b. You have at least fifteen (15) years of credited service as a member of either the teacher's retirement system or the board of education retirement system if you were an employee of the City or the Board of Education on or after April 28, 2010, and held a position represented by the recognized teacher organization on the last day of paid service.

(The above requirements, a and b, do not apply if you retire because of accidental disability);

AND

c. You have been employed by the City immediately prior to retirement as a member of such system, and have worked regularly for at least 20 hours per week;

AND

d. You receive a pension check from a retirement system maintained by the City.

EXCEPTIONS: Members of pension systems not maintained by the City may be eligible for health coverage

2. How do I Enroll for Health Benefits upon Retirement?

After receiving written verification of your retirement date from your pension system, or your agency benefit representative, you must obtain a *Health Benefits Application* (can be downloaded from the OLR website) or from your agency's benefits office. This application is to be completed in its entirety by you AND certified by your agency's health benefits officer. The application can then be forwarded to the Health Benefits Program located at 40 Rector Street, 3rd Floor, NY, NY 10006, by either your agency or yourself for processing (please allow 2-3 weeks for processing). **Incomplete or uncertified applications will be returned to you unprocessed.** Your health coverage as a retiree will be effective your date of retirement. If your *Health Benefits Application* is not submitted to the Retiree Health Benefits Program within 31 days of your date of retirement, this constitutes a late enrollment, except in the case of a disability retirement. As such, your effective date of health coverage as a retiree will be the first day of the month following the submission of your application.

Special Note: If at any time after you submit a Health Benefits Program application, you either rescind your retirement, or change your date of retirement, you must contact your agency and ask the health benefits representative to notify the Health Benefits Program office about the change. Failure to do so can delay your enrollment as a retiree, or reinstatement of your coverage as an active City employee.

3. What if I choose not to take health benefits as a retiree?

If you wish to waive your health coverage at the time of your retirement, you MUST complete a Health Benefits Program application and check "Waive Benefits" at the top of the application. If after your retirement you wish to obtain health coverage through the City, to apply, you must complete another application. The effective date of your coverage will be the first day of the month following a 90-day waiting period (this waiting period is waived if you are applying for coverage as a result of losing other coverage).

4. How do I enroll for health coverage at retirement if I and/or my spouse is eligible for Medicare?

Prior to your date of retirement, if you and/or any of your dependents are eligible for Medicare, you must contact the Social Security Administration and file for Medicare benefits. If you are enrolled in an HMO at retirement and wish to remain in the same health plan, the Medicare-eligible person must obtain a special enrollment application **directly** from the health plan. The special application must be submitted **directly** to the health plan *prior* to your date of retirement. A copy of the special enrollment application must accompany your Health Benefits Program application along with a copy of your Medicare card or Medicare Award Letter. If you enroll in a Medicare Supplemental Plan, a copy of your Medicare card or Medicare Award Letter must accompany your Health Benefits Program application. Failure to **submit the necessary documentation and applications could delay the effective date of your coverage as a retiree.**

Special Note: If you are eligible for Medicare at the time of your retirement, you may transfer your health plan. Also, please be advised that not all health plans accept Medicare enrollments and some Medicare HMOs may not be available in your area. Please call your

health plan directly for further information. You can also refer to the Summary Program Description on our website for more information.

POST- RETIREMENT PROCESS:

1. How will I pay for my cost of health benefits, such as the Optional Rider or Basic Health Coverage, if applicable?

Premiums for the Optional Rider and Basic Health coverage, if applicable, are deducted directly from your pension check. After retirement, It may take considerable time before health plan deductions are taken from a retiree's pension check. **Health coverage is continuous throughout the period in which there are no deductions as long as you are eligible to receive a pension from a City approved pension system.** When deductions do begin, retroactive deductions are made to pay for coverage during the period from retirement to the time of the first deduction. Subsequent pension checks will contain the normal monthly cost for your health coverage as well as a portion of the retroactive amount owed. Retroactive premium payments will be deducted at a rate of \$35 a month in addition to the regular per month deduction until the balance of the premiums owed is paid up.

2. What do I do if I am having incorrect health plan premiums deducted from my pension check?

First, check the website to compare your deductions with the rate chart. Rates are subject to change and notices are sent to retirees about these changes.

If you are having incorrect deductions taken from your pension check for health coverage, you **must** notify the Health Benefits Program **in writing** within 31 days of the discrepancy. Corrections will be made as quickly as possible after notification. Incorrect deductions will be refunded to you directly from the health plan. You may be asked to submit photocopies of pension check stubs (or quarterly statements for those with direct deposit) as proof of incorrect deductions. It is advised that you retain ALL pension check stubs and/or quarterly statements for your records.

Special Note: Medicare-eligible retirees enrolled in Medicare HMO Plans will receive enhanced prescription drug coverage from the Medicare HMO if their union welfare fund does not provide prescription drug coverage, or does not provide coverage deemed to be equivalent, as determined by the Health Benefits Program, to the HMO enhanced prescription drug coverage. The cost of this coverage will be deducted from the retiree's pension check. **Eligibility for the enhanced prescription drug coverage is determined automatically and cannot be elected or dropped by the retiree.**

3. When Do Premiums Change for Health Benefits?

There are usually two times when premiums change for retiree health benefits: January and July. Medicare HMOs are governed by Federal laws that require that they implement new premiums January 1 (which is reflected in your January 31 pension check). All other plans premiums change July 1 (which is reflected in your July 31 pension check).

4. How do I add/drop dependents from my health plan?

To add or drop dependents you must contact the Health Benefits Program. **Changes in coverage do not happen automatically.** You must obtain a Health Benefits Program application (can be downloaded from the OLR website) and submit the form within 31 days of the event necessitating the change in coverage. In the event of the death of a dependent, you must submit a copy of the Death Certificate. In the event of a divorce, you must submit a copy of the page(s) of your divorce decree that notes the effective date of the divorce. Coverage for dependent children terminates at the end of the month in which the dependent child turns 26. You must submit a Health Benefits Program application to drop him/her from your coverage.

Special Note: The effective date of termination is the date of death and the date of divorce.

5. When can I change health plans?

Retiree transfer periods occur every *even* numbered year. However, the Health Benefits Program may implement a special transfer period if significant changes occur in a health plan. In such cases, the Health Benefits Program will notify you in writing. Listed below are qualifying events that allow you to transfer plans without having to wait for a transfer period:

- You move into, or out of, a health plan service area
- Your health plan is no longer servicing your area
- You or your dependent become Medicare-eligible and your health plan will not cover the Medicare- eligible person(s)
- At retirement, provided you are Medicare-eligible
- OR
- You may use your “Once in A Lifetime” option (you must be retired *one year* to use this option) at any time to change your health plan.

Special Notes: If you are transferring out of a Medicare HMO voluntarily, you must disenroll from your health plan **in writing**, directly to your health plan (or complete a disenrollment application at your local Social Security Administration office). If both you and your dependent are enrolled in a Medicare HMO, separate disenrollment letters are required. If you transfer *into* a Medicare HMO, separate applications are required and are only available from the health plan. **When enrolling in a Medicare HMO, you must identify yourself as a *City of New York* retiree.**

6. What happens to my dependents health benefits upon my death?

Health benefits for dependents of retirees are only available under special circumstances such as the death of certain retirees who die as a result of a line of duty injury. (Contact the pension system to see if you qualify. Otherwise, dependents are eligible for COBRA (see next question). Contact the Health Benefits Program for a COBRA package.

7. What happens when my dependent(s) become ineligible for coverage?

The Federal **Consolidated Omnibus Budget Reconciliation Act** of 1985 (COBRA) requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate. All group health benefits,

including Optional Riders, are available. The maximum period of coverage for dependents of retirees is 36 months. Under the law, the retiree or family member has the responsibility of notifying the Health Benefits Program and the applicable welfare fund within 60 days of the death, divorce, domestic partnership termination, or of a child's losing dependent status. COBRA packages containing detailed information and an application can be obtained from the Health Benefits Program. **Once completed, COBRA applications must be submitted directly to your health plan.**

8. What do I do when I and /or my dependent, becomes eligible for Medicare?

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social security office **AS SOON AS YOU BECOME ELIGIBLE**. If you do not join Medicare, you will lose whatever benefits Medicare would have provided. The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare. Medicare-eligibles must be enrolled in Medicare Parts A and B in order to be covered by a Medicare HMO plan. **In order to remain in an HMO, you must complete a special enrollment application with your health plan.**

9. What if my Health Plan does not cover persons eligible for Medicare?

You must transfer to another health plan at retirement or prior to becoming Medicare-eligible after retirement.

10. What is the Medicare Part B Reimbursement Program and how do I enroll?

The City will reimburse retirees and their eligible dependents for the monthly premium for Medicare Part B, as well as dependents enrolled on Medicare disability. You must notify the Health Benefits Program, in writing, including submitting a copy of your Medicare card showing the Medicare Part A and Part B effective dates immediately upon receipt of your or your dependent's Medicare card. Once the Health Benefits Program is notified, our database is updated and you are automatically enrolled in the Medicare Part B reimbursement program.

Special Note: The Medicare Part B reimbursement is issued each August for the prior calendar year (January through December). You will only receive the reimbursement for the period of time that you were enrolled on Medicare Part B and covered by a City of New York health plan as a retiree. **Retirees who reside outside of the United States are NOT eligible for the Medicare Part B reimbursement since Medicare is not your primary insurer.**

11. Who Should I Notify if I change My Address?

- The City of New York Health Benefits Program (must be in writing)
- Your Health Plan
- Your Union welfare fund

- Your pension system

12. When should I contact the Health Benefits Program?

- For questions regarding deductions for health benefits taken from your pension check
- To obtain an application to make a change to your coverage such as adding/dropping dependents, adding/dropping the optional rider, waiving health coverage and to change plans (excluding Medicare HMOs which require a special application from the plan)
- To obtain information and an application for COBRA benefits
- To change your address (you must also notify your health plan, union welfare fund and pension system)
- To notify the program of your and /or your eligible dependent's enrollment on Medicare
- For questions regarding Medicare Part B reimbursements
- If your health coverage has been terminated by your health plan (call your plan first)
- If a dependent has been terminated by your health plan (call your plan first)

13. When should I contact my Health Plan?

- If you have *ANY* questions regarding covered services
- For claim allowances (How much will my plan pay towards a claim?)
- For information about the status of pending claims or claims disputes
- If your health coverage has been terminated by your health plan
- If a dependent has been terminated by your health plan
- For health plan service areas
- For a list of participating providers
- To obtain a special application to enroll in a Medicare HMO

14. When should I contact my Union/Welfare Fund?

If your welfare fund provides any of the following benefits:

- Prescription drug coverage
- Eyeglass coverage
- Dental benefits
- Life insurance
- Survivor benefits
- COBRA benefits