



OFFICE OF LABOR RELATIONS  
**EMPLOYEE BENEFITS PROGRAM**

40 Rector Street, 3<sup>RD</sup> Floor, New York, N.Y. 10006  
nyc.gov/olr

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**Important Information Concerning Coverage Under COBRA in the State of New York**

The attached information concerns coverage that may be available to you through the Federal Consolidated Omnibus Reconciliation Act ("COBRA") which provides access to continuing health coverage for a period of 18 months to 36 months depending on the reason for COBRA eligibility.

The State of New York recently enacted legislation intended to provide continued access to group health insurance for all persons eligible for COBRA or state continuation ("mini-COBRA") coverage up to a total of 36 months of coverage. For more information concerning how this may impact your coverage under COBRA please use the following link:

[http://www.ins.state.ny.us/cobra/cobra\\_ext\\_36.htm](http://www.ins.state.ny.us/cobra/cobra_ext_36.htm).

# CITY OF NEW YORK EMPLOYEE BENEFITS PROGRAM

## CONTINUATION OF COVERAGE APPLICATION

**Date of Qualifying Event**

/ /

**REASON FOR SUBMISSION (PLEASE PRINT CLEARLY) (CHECK ONE)**

- Termination of Employment/Member   
  Reduction of Work Schedule   
  Divorce or Legal Separation   
  Termination of Domestic Partnership  
 Death of Employee/Retiree   
  Loss of Eligibility as a Dependent Child  
 Present or former Contract                                  Present or Former                                  Social Security No.:  
 Holder's Name: \_\_\_\_\_ Health Plan \_\_\_\_\_

Relationship to Present or Former Contract Holder } <ul style="list-style-type: none"> <li><input type="checkbox"/> Self</li> <li><input type="checkbox"/> Spouse (former or current)</li> <li><input type="checkbox"/> Domestic Partner</li> <li><input type="checkbox"/> Son</li> <li><input type="checkbox"/> Daughter</li> </ul>	Present or Former City Employee's Welfare Fund: _____
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**APPLICANT INFORMATION (PLEASE PRINT)**

Last Name:	First Name:	M.I.:	Social Security Number:	Home Telephone #: ( )
Mailing Address:		Apt.:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City:		State:		Zip Code:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced		Date of Marital Status Event / /		

Is Applicant or Any Dependent Covered by Medicare?     Yes     No    If Yes, a COPY of the Medicare Card MUST be attached.

**FAMILY INFORMATION (PLEASE LIST ALL PERSONS TO BE COVERED, INCLUDING EMPLOYEE IF APPLICABLE (PLEASE PRINT))**

First Name	Last Name	Social Security Number	Date of Birth	Check if Applicable							
				Relationship					Full Time Student	Permanently Disabled	Covered by Other Group Insurance
				Self	Spouse	Dom. Partner	Son	Daughter			

**HEALTH PLAN REQUESTED (CHECK THE BOX BEFORE THE PLAN YOU WANT AND YOU MUST CHECK "YES OR NO" FOR THE OPTIONAL RIDER BENEFITS).**

- Aetna HMO                                   Aetna QPOS                                   Cigna Health                                   DC 37 Med-Team                                   Empire EPO - Nationwide  
 Empire HMO - New York                                   GHI-CBP/EBCBS                                   GHI HMO                                   HIP Prime HMO                                   HIP Prime POS  
 MetroPlus                                   Vytra Health Plan                                  OTHER \_\_\_\_\_  
 Optional Benefits:     Yes     No

**WELFARE FUND - COBRA**

Do you wish to purchase benefits from your welfare fund?     Yes     No

You must check "yes" to receive welfare fund benefits. A "no" response or not answering this questions will prevent you from receiving COBRA continuation benefits from your welfare fund. A copy of this form will be sent from the health plan to your welfare fund as proof that you have applied under COBRA for the City benefits. Before making this decision you should contact your welfare fund for available options and costs. You will pay the union welfare fund directly for the cost of these benefits. You may choose both the optional rider and the welfare benefits, either of these options or neither or these options.

**AUTHORIZATION**

I certify that the above information is correct. I fully understand that I am responsible for the full cost of my continuance of coverage and will be subject to the terms and conditions of the group contract.  _____ / / Applicant's Signature                                  Date	I choose to waive my rights to extend my current health coverage under COBRA. I wish to convert to a direct payment policy. Please send me a conversion contract.  _____ / / Applicant's Signature                                  Date
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**THIS NOTICE MUST BE MAILED DIRECTLY TO YOUR HEALTH PLAN FOR COBRA CONTINUATION COVERAGE OR FOR DIRECT PAYMENT CONVERSION (See Plan Description for address)**



**City of New York  
Office of Labor Relations  
Health Benefits Program**

**COBRA Premiums**

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you have the opportunity to continue health benefits coverage through the City of New York group.

You are responsible for paying the full premium for your plan and coverage. The premium levels indicated on the back of this page reflect 102% of the current rate (because these rates are subject to change, you should check with the plan to determine the premium at the time of your COBRA enrollment). Payments may be made monthly on the first of the month. There is usually a 30 day grace period. The City will not "carve out" benefits provided through your Welfare Fund that are similar to those available in your plan's Optional Rider. If you decide to purchase the Optional Rider, you must pay for the entire Optional Rider offered by your chosen plan. If you decide to purchase any of your Welfare Fund benefits, you should contact the Welfare Fund to determine what benefits are available, and the associated cost.

**Health Plan Addresses**

Payment should be mailed directly to the plan chosen for COBRA continuation coverage. The plan addresses are:

Aetna HealthCare  
151 Farmington Ave.  
Windsor, CT 06095  
Attn: Michele Wrenn

Empire BlueCross BlueShield  
3 Huntington Quadrangle, 3 Fl.  
Melville, NY 11747  
Attn: Lashern Pendergast

Metro Plus Health Plan  
160 Water Street, 3 Fl.  
New York, NY 10038  
Attn: COBRA/Finance Dept.

CIGNA Healthcare  
499 Washington Blvd, 4<sup>th</sup> Fl.  
Jersey City, NJ 07310  
Attn: City of New York

GHI\EBCBS\*  
GHI HMO  
441 Ninth Ave.  
New York, NY 10001  
Attn: Membership Department

Vytra  
441 Ninth Avenue  
New York, NY 10001  
Attn: Membership Department

DC 37 Med-Team  
125 Barclay Street, 3 Fl.  
New York, NY 10007  
Attn: Robert Hasiak

HIP HMO  
HIP POS  
441 Ninth Avenue  
New York, New York 10001  
Attn: Membership Department

**\*The GHI-CBP/EBCBS is offered as package under COBRA. The premium should be sent to the Group Health Inc. address indicated above.**

**CONVERSION CONTRACTS - City Health Plan Benefits**

If you do not wish to continue coverage under COBRA you may use the same application to request direct payment conversion contracts from all plans. Conversion contract payments will be due quarterly. Upon receipt of an application for conversion, the health plan will send you a direct payment contract and a bill. Generally, conversion contracts will be more expensive than COBRA for the same benefits or will offer benefits less comprehensive than COBRA, with the exception of certain Medicare supplemental contracts. Optional benefits are not available under conversion. You may purchase either Group Health Inc. or Empire BlueCross BlueShield direct payment plan separately. Decide whether direct payment conversion or COBRA continuation coverage is best to meet your needs. If you decide to continue coverage under COBRA, you will again be eligible to obtain direct payment contracts when COBRA terminates. Contact the health plan for more information concerning direct payment contracts.

**Welfare Fund Benefits**

Contact your welfare fund directly for COBRA rates. If you do not wish to continue coverage of benefits provided by your welfare fund under COBRA, conversion to private coverage may be available for medical and life insurance benefits within 45 days of termination of coverage. If you intend to obtain welfare fund benefits under COBRA, please so indicate on the COBRA Continuation of Coverage application.

**NON-MEDICARE COBRA Rates Effective July 1, 2014**

PLAN	Coverage	COBRA RATE
AETNA HMO	INDIVIDUAL BASIC	\$764.34
	FAMILY BASIC	\$2,287.58
	INDIVIDUAL with RIDER	\$903.47
	FAMILY with RIDER	\$2,623.98

CIGNA	INDIVIDUAL BASIC	\$1,152.90
	FAMILY BASIC	\$2,979.63
	INDIVIDUAL with RIDER	\$1,364.05
	FAMILY with RIDER	\$3,611.80

EMPIRE EPO	INDIVIDUAL BASIC	\$1,066.30
	FAMILY BASIC	\$2,666.13
	INDIVIDUAL with RIDER	\$1,195.44
	FAMILY with RIDER	\$2,982.72

EMPIRE HMO	INDIVIDUAL BASIC	\$822.21
	FAMILY BASIC	\$2,135.76
	INDIVIDUAL with RIDER	\$951.36
	FAMILY with RIDER	\$2,452.34

GHI HMO	INDIVIDUAL BASIC	\$715.01
	FAMILY BASIC	\$1,822.16
	INDIVIDUAL with RIDER	\$883.24
	FAMILY with RIDER	\$2,251.10

GHI-CBP/BCBS	INDIVIDUAL BASIC	\$517.95
	FAMILY BASIC	\$1,346.23
	INDIVIDUAL with RIDER	\$647.36
	FAMILY with RIDER	\$1,583.31

PLAN	Coverage	COBRA RATE
HIP PRIME HMO	INDIVIDUAL BASIC	\$618.07
	FAMILY BASIC	\$1,515.29
	INDIVIDUAL with RIDER	\$763.50
	FAMILY with RIDER	\$1,871.59

HIP PRIME POS	INDIVIDUAL BASIC	\$1,308.08
	FAMILY BASIC	\$3,206.04
	INDIVIDUAL with RIDER	\$1,781.98
	FAMILY with RIDER	\$4,360.51

DC 37 MED TEAM PROGRAM (NO RIDER Available)	INDIVIDUAL BASIC	\$618.07
	FAMILY BASIC	\$1,515.29

METROPLUS HEALTH PLAN	INDIVIDUAL BASIC	\$610.87
	FAMILY BASIC	\$1,497.65
	INDIVIDUAL with RIDER	\$752.90
	FAMILY with RIDER	\$1,820.90

VYTRA	INDIVIDUAL BASIC	\$677.44
	FAMILY BASIC	\$1,781.76
	INDIVIDUAL with RIDER	\$834.86
	FAMILY with RIDER	\$2,191.18

**MEDICARE Related Plans COBRA Rates Effective July 1, 2014**

PLAN	Coverage	COBRA RATE
GHI SENIOR CARE	PER PERSON BASIC	\$164.08
	PER PERSON with RIDER	\$273.39

GHI HMO	PER PERSON BASIC	\$434.47
	PER PERSON with RIDER	\$493.63

DC37 MED TEAM PROGRAM	PER PERSON BASIC	\$164.08
	RIDER NOT AVAILABLE	

EMPIRE MEDICARE RELATED PLAN	ONE PERSON BASIC	\$250.35
	TWO PERSONS BASIC	\$494.73
	ONE PERSON with RIDER	\$420.77
	TWO PERSONS w/RIDER	\$835.57

Aetna PPO/ESA	PER PERSON BASIC	\$168.30
	PER PERSON with RIDER	\$350.24

**NOTE:** If you were enrolled in a Medicare HMO you **MUST** contact your health plan **DIRECTLY** for benefit and cost information regarding continuation of coverage.

Return the completed COBRA form to your chosen plan. Addresses are listed on the third page of this pamphlet. Wait for notification from the plan before mailing in your first payment. Checks and/or money orders must be made payable to the health plan and mailed **DIRECTLY** to the plan. Enrollees of all plans not listed must contact the plan **DIRECTLY** for enrollment options.



**City of New York  
Office of Labor Relations  
Health Benefits Program**

**Notice of Rights**

**WHEN YOUR HEALTH BENEFITS TERMINATE**

The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-2721, Title X), also known as COBRA, was enacted April 7, 1986. This law requires that, effective July 1, 1987, in addition to offering normal conversion opportunities, the City and the union welfare funds must offer employees and their families the opportunity for a temporary extension of group health and welfare fund coverage (called "continuation of coverage") at 102% of the group rates, in certain situations in which benefits under either City basic or the applicable welfare fund would be reduced or terminated. This notice is intended to inform you of your rights and obligations under the continuation coverage provisions of this law as well as your normal conversion option.

As a result of collective bargaining agreements, Medicare-eligible enrollees and/or their Medicare-eligible dependents will be offered continuation benefits similar to COBRA if a COBRA event should occur. **(See Medicare-Eligible Section.)**

## **Employees**

All City group health benefits including the optional benefits riders are available under COBRA continuation coverage. Welfare fund benefits eligible for continuation under COBRA are dental, vision, prescription drugs and other related medical benefits. Welfare funds offer core benefits (prescription drugs and major medical plans) and non-core benefits (dental and vision) which may be purchased separately or combined with City core benefits.

If you are a non-Medicare-eligible employee covered by the City program, you have the right, in certain situations, to continue benefits if you lose your coverage because of a reduction in your hours of employment; or upon the termination of your employment (for reasons other than gross misconduct on your part); or if you take an unpaid leave of absence. If you are Medicare-eligible, you may be entitled to continuation of coverage as is described in the Medicare-eligible section below.

## **Retirees**

You and your dependents are eligible to receive City-paid health care coverage if you have, at the time of retirement:

- a. 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 at the time of your retirement you must have at least five (5) years of credited service as a member of a retirement or pension system maintained by the City). This requirement does not apply if you retire because of accidental disability; and
- b. 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
- c. You receive a pension check from a retirement system maintained by the City.

If you do not meet these eligibility requirements, you and your dependents (if not Medicare-eligible) may continue under COBRA the benefits you received as an active employee, for a period of 18 months at 102% of the City's cost. If your welfare fund benefits are reduced at retirement, you are eligible to continue those benefits that were reduced under the welfare fund as a COBRA enrollee for a period of 18 months at 102% of the cost to the union welfare fund. You should contact your union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators is enclosed or can be obtained from your payroll or personnel office. If you are eligible for Medicare, see the Medicare-eligible section.

## **Spouse/Domestic Partners and Dependents**

*If you are the non-Medicare-eligible spouse/domestic partner of an eligible employee or a retiree, you have the right to continue coverage under any of the available NYC health benefits plans and the applicable welfare funds if your health insurance or welfare fund benefits are reduced or terminated for any of the following reasons:*

- 1) The death of your spouse/domestic partner;

- 2) The termination of your spouse/domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse/domestic partner's hours of employment;
- 3) Divorce or legal separation from your spouse.

In the case of an eligible dependent child of an employee or retiree (including a newborn child who was born to the covered beneficiary or an adopted child who is placed for adoption with the covered beneficiary during a period of COBRA continuation coverage) he or she has the right to continue coverage under any of the available NYC health benefits plans and the applicable welfare fund if coverage is reduced or terminated for any of the following reasons:

- 1) The death of the covered parent;
- 2) The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment;
- 3) The dependent ceases to be a "dependent child" under the terms of the Employee Benefits Program;
- 4) Retirement of the covered parent (see "Retiree" above).

**If you are a Medicare-eligible spouse/domestic partner or dependent, see section on Medicare-eligible's.**

### **Disabled Persons**

If a disability has led to Medicare eligibility, see section on Medicare-eligibles below.

Covered persons who are disabled, under the definition established by the Social Security law, up to 60 days after the COBRA qualifying event of termination of employment or reduction of hours, are entitled to continue coverage for up to a total of twenty-nine (29) months from the date of the initial qualifying event. The cost of coverage during the last eleven (11) months of this extended period is one hundred and fifty percent (150%) of the City cost for the benefit. Persons so disabled must inform the health plan within sixty (60) days of the disability determination and within thirty (30) days of disability ceasing.

### **Medicare-Eligibles**

Employees, retirees, spouses/domestic partners and dependents who are eligible for Medicare may be eligible to receive continued coverage, similar to COBRA, under the City's Medicare-Supplemental plans. Periods of eligibility shall date from the original qualifying event up to eighteen (18) months in the case of loss of coverage because of termination of employment or reduction in hours, or up to thirty-six (36) months in the case of loss of coverage for all other reasons.

If a COBRA qualifying event occurs and you lose coverage, but you and/or your dependents are Medicare-eligible, you may continue coverage by using the COBRA Continuation of Coverage application form. You should indicate your Medicare claim number and effective dates where indicated on the form for Medicare-eligible family members. If you and/or your dependents are about to become eligible for Medicare, and are already continuing coverage under COBRA, inform the carrier of Medicare eligibility for you and/or your dependents, at least thirty (30) days prior to date of Medicare eligibility. COBRA-enrolled dependents of the person who becomes Medicare eligible will be able to continue their COBRA coverage, whether or not the Medicare-eligible person enrolls in the Medicare-Supplemental coverage. The COBRA continuation period for dependents will be unaffected by the decision of the Medicare-eligible employee or retiree.

**NOTE:** You should contact your carrier for information about other Medicare-Supplemental plans which are offered; some other plans may be better suited to your needs and/or less costly than the plan which is provided under the City's contract.

## Notice

Under the law you have sixty (60) days from the date you receive this notice to elect continuation coverage for your City basic and/or optional benefits. Contact your welfare fund administrator for further instructions on how to continue your welfare fund benefits. Payments of the initial monthly premium may accompany the enclosed Continuation of Coverage Application opting for continuation. However, under the law you have a grace period of 45 days from the date you applied for COBRA coverage to pay the premium. You will receive a partial bill for any remaining portion of the following calendar month to bring your billing date to the first of the month. All subsequent bills will be charged from the first day of the month during your COBRA continuation period. Payment shall be on a monthly basis. There is a 30-day grace period for subsequent late payments.

If you choose COBRA continuation coverage, and you are not Medicare-eligible, the City is required to offer you the same coverage which is provided to similarly situated employees, retirees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for a maximum of thirty-six (36) months unless you lost coverage because of a termination of employment or reduction in hours. In the latter case, the required continuation coverage period is a maximum of 18 months. The maximum period of continuation begins on the first day of the month following the month in which the initial qualifying event occurred, regardless of when any additional events may take place. However, the law also provides that your continuation of coverage may be cut short for any of the following reasons:

- 1) The premium for continuation coverage is not paid in a timely fashion;
- 2) The continuation enrollee becomes covered as an employee or dependent under another group health or welfare plan (under this occurrence the spouse and dependents may continue their COBRA coverage for the remaining months of eligibility).

**NOTE:** If the new plan contains any exclusion or limitation for a pre-existing condition of the continuation enrollee, then coverage may not be terminated.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay 102% of the cost of benefits for the continuation coverage. Also, at the end of the continuation period you are allowed to convert to a self-paid direct payment policy.

## Conversion Options

If you do not choose continuation, your City group coverage will end. You will still be offered the opportunity to convert your City health insurance benefits to a non-City direct payment health insurance policy and, where applicable, convert certain welfare fund benefits. Benefits offered under the non-City group direct payment health insurance policy are offered on a quarterly basis for an indefinite period of time, provided premiums are paid on time. These benefits may vary from the City's "basic" health benefits package in terms of scope of benefits and cost. Benefits available from welfare funds that may be converted to direct payment are insured medical/ surgical/ hospital and life insurance coverage. Such benefits may be converted within 45 days of termination of coverage.

In order to receive continuation coverage for welfare fund benefits or to convert to direct payment, you must contact your welfare fund directly.

For further information about this law, employees should contact their agency benefits representative and retirees should contact the Health Benefits Program, 40 Rector Street - 3rd Fl., New York, New York 10006.