# New York City

Office of Labor Relations
Health Benefits Program
Employee Benefits Program

HBP
Health Benefits Program

# Summary Program Description (SPD)

Effective January 1, 2026, the City of New York will be offering a new health plan, the NYC Employees PPO plan (NYCE PPO), replacing the current GHI CBP/Anthem BlueCross and BlueShield plan. Active employees and pre-Medicare retirees, and their eligible dependents under 65 will automatically be transferred to the new health plan with no gap in coverage unless they choose a different plan during the Annual Fall Transfer Period in November.

For information about the NYCE PPO, please refer to the Summary of Health Plans section in this Summary Program Description or visit the NYCE PPO website at www.nyceppo.com or call (212) 501-4444

The City of New York

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***Current as of November 21, 2025***

# THE CITY OF NEW YORK'S HEALTH BENEFITS PROGRAM

## INTRODUCTION

Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program. These benefits are intended to provide you with the fullest possible protection that can be purchased with the available funding.

This Summary Program Description (SPD) provides you with information about your benefits under the New York City Health Benefits Program. This SPD is a description of current benefits, which are subject to change.

## EMPLOYEE SELF-SERVICE

### HOW TO USE SELF-SERVICE FOR HEALTH BENEFITS?

Employee Self-Service (ESS) is an online tool that employees use to enroll or make changes to their personal, health benefits, pay, tax and deduction information.

For NYCAPS Central agencies, employees should use Employee Self Service (ESS) to enroll in or make changes to their health benefits. For assistance in using ESS, employees should contact their HR department or NYCAPS Central directly. Employees in need of a password for ESS should contact NYCAPS at (212) 487-0500 or email their request to **nycapscentral@dcas.nyc.gov**.

If you are an employee of one of the following NYCAPS agencies, however, you must contact either your HR or Benefits/Payroll Office directly to enroll in or make changes to their health benefits:

- Police Department
- Fire Department
- Department of Sanitation
- Department of Education (contact HR Connect at (718) 935-4000)
- District Attorney Offices
- Department of Investigation
- New York City Housing Authority

Employees of non-NYCAPS agencies must contact either their HR or Benefits/Payroll Office directly to enroll in or make changes to their health benefits:

- NYC Health + Hospitals (contact Shared Services at (646) 458-5634)
- New York City School Construction Authority
- Cultural Institutions
- Libraries
- CUNY Senior Colleges

## SECTION I – EMPLOYEE HEALTH BENEFITS

### YOUR RESPONSIBILITIES

It is important that you know how your health plan works and what is required of you. Here are some important things that you need to remember:

- Contact your agency health benefits or payroll office to add new dependents (newborn, adoption, marriage) *within* 30 days after the event;
- Notify your agency when you change your address;
- Review your payroll check to ensure appropriate premiums are deducted;
- Know your rights and responsibilities under COBRA continuation coverage.

### IF YOU NEED ASSISTANCE

Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500. Department of Education employees can contact HR Connect at (718) 935-4000, and H + H employees can contact Shared Services at (646) 458-5634.

- For questions concerning eligibility and enrollment, including changes in family status other than domestic partnership issues
- For questions regarding deductions for health benefits
- For Transfer Period information
- To obtain information and an application for COBRA benefits
- To change your address
- If health coverage has been terminated for you and/or your dependents

Employees with access to Employee Self Service (ESS) through CityShare can check their coverage status and make changes.

### WHEN SHOULD I CONTACT MY HEALTH PLAN?

- If you have questions regarding covered services
- To obtain written information about covered services
- For information about the status of pending claims or claim disputes
- For claim allowances (How much will a plan pay towards a claim?)
- For health plan service areas

When writing to a health plan, include your name and address, certificate number, date(s) of service, and claim number(s), if applicable. Some plans also allow inquiries through their Websites. (Refer to your health plan identification card or plan booklet for telephone numbers.)

### WHEN SHOULD I CONTACT MY UNION/WELFARE FUND?

When you are adding/dropping dependents from your union/welfare fund coverage and for information about:

- Prescription drug coverage (if applicable)
- Vision benefits
- Dental benefits
- Life Insurance (if applicable)

### WHEN SHOULD I, AS AN ACTIVE EMPLOYEE, CONTACT THE HEALTH BENEFITS PROGRAM?

- To add or drop a domestic partner
- To register to attend a Transition to Retiree Health Benefits seminar prior to retiring. Visit the Health Benefits Program at nyc.gov/hbp to register and view available seminar dates and times.

## ELIGIBILITY

To be eligible for participation in the City Health Benefits Program, employees must meet all of the following criteria:

1. You work for the City of New York or one of the following Participating Employers: New York City Department of Education, City University of New York, NYC Health + Hospitals, New York City Housing Authority, New York City School Construction Authority, New York Public Library, Queensborough Public Library, Brooklyn Public Library and certain Cultural Institutions.
2. You work -- on a regular schedule -- at least 20 hours per week; and
3. Your appointment is expected to last for more than six months.

Dependents are eligible if their relationship to the eligible participant is one of the following:

1. A legally married spouse, but never an ex-spouse.
2. A domestic partner. More details concerning eligibility and tax consequences are available from your agency or the Office of Labor Relations Domestic Partnership Liaison Unit at 212-306-7605 or online at nyc.gov/hbp.
3. Children under age 26 (whether married or unmarried)**:**
   a) natural children;
   b) children for whom a court has accepted a consent to adopt and for the support of whom an employee has entered into an agreement;
   c) children required to be covered under a qualified medical child support order until the court order expires, at which time the child may continue to be eligible for coverage under (a) or (b) above;
   d) children for whom a court of law has named the employee as legal guardian;
   e) any other child who lives with an employee in a regular parent/child relationship and is the employee's tax dependent. A child is the employee's tax dependent if the employee claims the child on his/her income tax return as a dependent.

   Coverage will terminate for children (other than eligible disabled children) at the end of the month in which the child reaches age 26.

   **Exception**: Unmarried, disabled children age 26 and older, who cannot support themselves, are eligible for continued coverage if the following criteria are met:

   1. the disability occurred before the age at which the dependent coverage would otherwise terminate, and
   2. the proof of disability was approved by the health plan at least 31 days before the date the dependent reached age 26.

   **The eligibility for such dependents only applies to current employees whose disabled dependent children reach the age limitation while covered by a City health plan. New employees with disabled dependent children, already over the age limitation, may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage, if the child is already over age 26.**

## HEALTH PLAN COVERAGE FOR NYC HEALTH + HOSPITALS MANAGERIAL GROUP 11 EMPLOYEES HIRED ON OR AFTER JULY 28, 2025

NYC Health + Hospitals Managerial Group 11 employees hired on or after July 28, 2025, and their eligible dependents, will only be eligible to enroll in the MetroPlus Health Gold Plan, and must remain in the MetroPlus Health Gold Plan for the first year (365 days) of employment.

After 365 days of employment, the employee will have the option of either remaining in the MetroPlus Health Gold Plan or selecting a different health plan within 30 days before the end of the 365-day period. If a new health plan is selected, the new plan will be effective on the 366th day.

Only after the 365th day can the employee participate in any Annual Fall Transfer Period. (See Annual Fall Transfer Period section below for details.)

## ENROLLMENT

### HOW TO ENROLL FOR HEALTH BENEFITS

- For instructions on how to enroll, you must contact your agency health benefits or payroll office. Employees of a NYCAPS Centralized agency must log into ESS. Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634. Your enrollment request must be submitted within 30 days of your appointment date (for exceptions, see Effective Dates of Coverage section). If you do not submit your request on time, the start of your coverage will be delayed and you may be subject to loss of benefits.
- New employees, employees enrolling for the first time or current employees requesting to add dependents are required to provide acceptable documentation to support the eligibility status of all persons to be covered on their City health plan coverage.
    a. If you are including a spouse on your coverage, and you have been married for one year or less, you must submit a Government issued Marriage Certificate. If you are including your spouse on your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns from the last two years, (only send the first page of each tax return which shows your spouse) OR Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.
    b. If you are including a domestic partner on your coverage, and you have been registered for one year or less, you must submit a Government issued Certificate of Domestic Partnership. If you are including a domestic partner on your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

At retirement you must file a Health Benefits Application with your payroll or personnel office prior to retirement to continue your coverage into retirement.

**Note - DOUBLE CITY Coverage Prohibited**

No person can be covered by two City health contracts at the same time. In other words, no person can be covered as both an employee/retiree and a dependent of another City employee/retiree at the same time.

Eligible dependent children must be enrolled as dependents under one City employee/retiree.

If either a spouse or a domestic partner, or eligible dependent, is enrolled as a dependent of the other, the spouse/domestic partner/eligible dependent may pick up coverage in their own name if the other's contract is terminated.

### HEALTH PLAN PREMIUMS

There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require an employee payroll deduction. Payroll deductions for health coverage are made on a pre-tax basis (See Medical Spending Conversion). Enrollees may purchase additional benefits through Optional Riders (i.e. prescription drugs). Please refer to the Employee Health Plan Rate Chart available on the Health Benefits Website.

### OPTIONAL RIDERS

All health plans offered by the New York City Health Benefits Program, except DC 37 Med-Team, have an optional rider. The optional rider is for benefits not included in the basic City health plan.

#### GHI-CBP AND HIP HMO

The optional riders for the GHI-CBP Plan and the HIP HMO offer prescription drug benefits and additional ancillary benefits. The GHI-CBP optional rider, in addition to the prescription drug benefit, provides an enhanced major medical plan (increased reimbursement for certain services from non-participating providers). The HIP HMO optional rider includes Durable Medical Equipment (DME) and

Private Duty Nursing, as well as prescription drug coverage. Please see the Summary of Health Plans section and contact the health plan directly for more information about the optional riders.

Most employees/pre-Medicare retirees get prescription drug benefits through their union welfare funds. If the welfare fund is providing prescription drug benefits, the employee/pre-Medicare retiree enrolled in either the GHI-CBP or the HIP HMO will not be eligible to purchase the prescription drug portion of the optional rider. Those Employees/pre-Medicare retirees enrolled in the GHI-CBP Plan and the HIP HMO Plan who receive prescription drug benefits through their union welfare funds will only be able to purchase the additional ancillary benefits portion of the optional rider. Employee payroll/pension deductions will be adjusted accordingly to either Optional Rider or Rider Other (ancillary benefits only).

If your welfare fund provides no prescription drug coverage for employees, then you are only eligible to purchase the optional rider comprised of both the prescription drug coverage and additional ancillary benefits.

If your welfare fund provides either no or limited prescription drug coverage to pre-Medicare retirees, then you are only eligible for the optional rider. Please check with your union for more information about prescription drug coverage.

### NYCE PPO PLAN (EFFECTIVE JANUARY 1, 2026)

The optional rider for the NYCE PPO Plan offers prescription drug benefits only.

Most employees/pre-Medicare retirees get prescription drug benefits through their union welfare funds. If the welfare fund is providing prescription drug benefits, the employee/pre-Medicare retiree enrolled in the NYCE PPO Plan will not be eligible to purchase the prescription drug optional rider.

If your welfare fund provides no prescription drug coverage for employees, then you are eligible to purchase the optional rider for prescription drugs.

If your welfare fund provides either no or limited prescription drug coverage to pre-Medicare retirees, then you are eligible to purchase the optional rider for prescription drugs. Please check with your union for more information about prescription drug coverage.

### ALL OTHER CITY HEALTH PLANS

The Optional Rider provided through all other City health plans, except GHI-CBP and HIP HMO, consist only of a prescription drug plan. If the union welfare fund provides prescription drug benefits, the employee/pre-Medicare retiree may purchase the optional rider. The employee/pre-Medicare retiree will pay for the optional rider in addition to benefits provided through their welfare fund. Please refer to the Summary of Health Plans section for information regarding the optional riders available to you.

## INCORRECT DEDUCTIONS FROM YOUR PAYCHECK

Please review your payroll health deduction carefully to be sure the amount is correct. If the deduction is incorrect, you must contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000) within 30 days. Adjustments will be made accordingly. Otherwise, the deduction will be deemed as accurate.

## WAIVER OF HEALTH BENEFITS

Every employee or retiree eligible for City health benefits must either enroll for coverage or waive membership by contacting their agency health benefits or payroll office: NYCAPS Central at (212) 487-0500, Department of Education HR Connect at (718) 935-4000 or H + H Shared Services at (646) 458-5634.

## EFFECTIVE DATES OF COVERAGE

Coverage becomes effective according to the following:

### FOR EMPLOYEES

1) For employees appointed from Civil Service lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement, coverage begins on your appointment date, provided your Health Benefits enrollment request for has been received by your agency personnel or payroll office within 30 days of that date.
2) For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement for employment, coverage begins on the ninety-first day of continuous employment, provided that your Health Benefits enrollment request has been submitted within that period.

Note: Special Enrollment Qualifying Event for Employees who are victims of domestic violence or gender-based violence: Employees who are victims of domestic violence or gender-based violence who separate from a household member due to an incident or incidents of domestic or gender-based violence shall be allowed to enroll for City health benefits or make reasonable changes in their current City health benefits at any time during the calendar year. The effective date of enrollment or benefit change will be the first day of the month following the processing of the health benefits application.

### FOR ELIGIBLE DEPENDENTS

Coverage for eligible dependents will begin on the day that you become covered. Dependents acquired after you submit a request for Health Benefits will be covered from the date of marriage, domestic partnership, birth or adoption; provided that you submit the required notification and documentation within 30 days of the event (see Changes in Family Status section).

For enrollment information and instructions, access ESS or contact your agency health benefits or payroll office.

## CHANGES IN FAMILY STATUS - ADDING OR DROPPING DEPENDENTS

Employees should report all changes in family status either through ESS or by contacting their agency health benefits or payroll office **within 30 days** after the event. Changes should also be reported by the employee to their union/welfare fund.

Changes include adding a dependent due to marriage, domestic partnership, birth or adoption of a child, and to drop dependents due to death, divorce, termination of domestic partnership, or a child reaching an ineligible age. If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions.

For NYCAPS Central agencies, employees should enter their family status change directly in Employee Self Service (ESS). NYCAPS Central will mail the employee the necessary paperwork, including a request for any required documentation, if applicable.

## ANNUAL FALL TRANSFER PERIOD

A Health Benefits Transfer Period is held once each year for coverage effective January 1st of the following year. During this period, you may transfer from your current health plan to any other plan for which you are eligible, or you may add or drop Optional Rider coverage in your current plan. If you previously waived health insurance coverage, you may elect coverage during this period.

If you did not select the Optional Rider when you first enrolled, you may add these additional benefits only during a Transfer Period. You may also add the Optional Rider at retirement.

**Procedures for Employee Health Plan Transfers** — In order to transfer from one plan to another or to add Optional Rider coverage, you must submit your request through ESS or contact your agency health benefits or payroll office during the Annual Transfer Period. ***Once the transfer request is submitted the change is irrevocable for the remainder of the calendar year.***

***Required Documentation for Dependent Changes*** — If you are including a spouse on your coverage, and you have been married for one year or less, you must submit a Government issued Marriage Certificate. If you are including a spouse on your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns

from the last two years, (only send the first page of each tax return which shows your spouse) OR Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements. If you are including a domestic partner on your coverage, and you have been registered for one year or less, you must submit a Government issued Certificate of Domestic Partnership. If you are including a domestic partner on your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

## PRE-TAX BENEFITS PROGRAM

The City of New York Employee Benefits Program provides two programs, the Medical Spending Conversion (MSC) and the Health Care Flexible Spending Account (HCFSA), that offer participants the opportunity to use pre-tax funds to increase take-home pay. These programs are administered through the Flexible Spending Accounts (FSA) Program. Please contact the Flexible Spending Accounts Program Administrative Office at (212) 306-7760 for additional information or online at www.nyc.gov/fsa.

## MEDICAL SPENDING CONVERSION

1. **Premium Conversion Program**

   All employees who have payroll deductions for health benefits are automatically enrolled in the MSC Premium Conversion Program. The Premium Conversion Program allows for premiums of health plan deductions on a pre-tax basis, thus reducing the amount of gross salary on which federal income and Social Security (FICA) taxes are calculated. Employees may decline enrollment in the Premium Conversion Program when they first become eligible for health plan coverage or during the FSA Open Enrollment Period, which is in the fall of each calendar year. To do so, employees must complete an MSC Premium Conversion Program Form and the Health Benefits Application and submit them for approval to their personnel office.

2. **Health Benefits Buy-Out Waiver (Employees Only)**

   The MSC Health Benefits Buy-Out Waiver Program entitles all eligible employees to receive a cash incentive payment for waiving their City health benefits if non-City group health coverage is available to them (e.g., a spouse's/domestic partner's plan, coverage from another employer). Annual incentive payments, which are taxable income, are $500 for those waiving individual coverage and $1,000 for those waiving family coverage. Incentive payments will be made in June and December of the Plan Year and will be included in the employee's regular paycheck. This amount will be prorated for any period less than six months by the number of days the employee is participating in the MSC Health Benefits Buy-Out Waiver Program. To do so, employees must complete an MSC Health Benefits Buy-Out Waiver Program Form and the Health Benefits Application and submit them for approval to their personnel office.

   Eligible employees who have waived health benefits coverage may enroll for coverage subject to the waiting period. Reinstatement of Coverage is only possible within 30 days of a Qualifying Event or during the Open Enrollment Period. Such enrollment will be on a pre-tax basis (unless enrollment in the Premium Conversion Program is declined).

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

The Health Care Flexible Spending Account (HCFSA) Program is designed to help employees pay for necessary out-of-pocket medical, dental, vision, and hearing aid expenses not covered by insurance. HCFSA is funded through pre-tax payroll deductions, thereby effectively reducing the employee's taxable income. For more information, visit the HCFSA website at: https://www.nyc.gov/site/olr/fsa/fsa-hcfsahome.page

## LEAVE OF ABSENCE COVERAGE

### FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) entitles eligible and approved employees up to a maximum of 12 weeks of paid and/or unpaid leave in a 12-month period to care for an immediate family member or for the serious illness of the employee. FMLA leave may also be taken in connection with certain events related to a family's service in the military. Eligible and approved employees using this paid and/or unpaid leave can continue their basic City health coverage, which is paid by the City, for up to a maximum of 12 weeks. Employee payroll deductions for health plan premium, or optional rider, if applicable, will resume upon return to work.

EMPLOYEE ELIGIBILITY

An employee is eligible for leave under FMLA if they have worked:

- For the City of New York for at least 12 months; and
- At least 1,250 hours during the 12-month period prior to the start of the FMLA leave.

LEAVE ENTITLEMENT

An eligible employee may apply for leave under FMLA for one or more of the following reasons:

- For the care of the employee's newly born child, or a child newly placed for adoption or foster (within one year of birth or placement).
- For the care of an immediate family member (employee's spouse, child, or parent who has a serious health condition) Please note that parents of spouses are not included in this provision.
- When the employee is unable to work because of a serious illness.
- For reasons related to a family member's service in the military, including, leave for certain reasons related to a family member's foreign deployment, and leave when a family members is a current servicemembers or recent veteran with a serious injury or illness.

When the continuation of basic City health coverage ends under FMLA, a member and or eligible dependents may each have the right to continue City health coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please refer to Section III – COBRA for eligibility information.

Contact your agency personnel office to determine eligibility and to request leave under FMLA.

### SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)

Special Leave Of Absence Coverage (SLOAC) entitles the City of New York employees (approved for leave) to a maximum of 18 weeks or 4 months in a rolling 12-month period during unpaid leave resulting from a disability or serious illness of the employee. Approved employees taking unpaid leave under SLOAC can continue basic City health coverage, which is paid by the City. Employee payroll deductions for health plan premium, or optional rider, if applicable, will resume upon return to work.

CONCURRENT USAGE OF FMLA AND SLOAC: An employee not satisfying the eligibility requirements under FMLA, or an employee who was on paid leave for all 12 weeks under FMLA, would have the maximum allowable coverage of 18 weeks or 4 months under SLOAC.

Contact your agency personnel office to determine eligibility and to request leave under SLOAC.

Please be advised that coverage previously received during an unpaid leave under FMLA serves to reduce the maximum allowable coverage period under SLOAC. For instance, one-month unpaid leave coverage under FMLA results in a maximum of 3 months coverage allowable under SLOAC.

When the continuation of basic City health coverage ends under SLOAC, a member and or eligible dependents may each have the right to continue City health coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please refer to Section III – COBRA for eligibility information.

## TRANSFER FROM ONE CITY AGENCY TO ANOTHER

If you leave the employment of one City agency and you are covered under the City's Health Benefits Program, and subsequently become employed by another City agency and you are eligible to enroll for health coverage, your coverage will become effective on your appointment date at the new agency, provided that no more than 90 days have elapsed since your coverage terminated at the first agency. You must remain in the same health plan unless you experience certain qualifying events. Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634) for additional information.

## CHANGE OF UNION OR WELFARE FUND MEMBERSHIP

Title changes that result in a change of union or welfare fund membership may require a change in payroll deductions for any Optional Rider coverage. You should contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634) within 30 days if your union or welfare fund has changed.

If you are a DC 37 member enrolled in Med-Team and you will no longer be in DC 37, then you must select another health plan.

## TERMINATION AND REINSTATEMENT

### WHEN COVERAGE TERMINATES

Coverage terminates:

- for an employee or retiree and covered dependents, the day after the employee's last day of employment with the City or Participating Employer or when a retiree stops receiving a pension check (with the exception of employees on FMLA or SLOAC).
- for an employee and covered dependents, the day after the employee no longer meets the eligibility criteria for participation in the City Health Benefits Program.
- for a spouse, when divorced from an employee or retiree.
- for a domestic partner, when partnership terminates.
- for dependent children (other than eligible disabled children) at the end of the month in which the child reaches age 26.
- for all dependents, unless otherwise eligible, the day after the death of the City employee or retiree.

If your spouse, or your domestic partner, is eligible for City health coverage as either an employee or a retiree, and is enrolled as your dependent, the person enrolled as dependent may pick up coverage in his/her own name within 30 days if the employee's City coverage terminates.

### REINSTATEMENT OF COVERAGE

If you have been on approved leave without pay, or have been removed from active pay status for any other reason, your health coverage may have been interrupted. Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634) within 31 days of your return to work.

- If you are returning from an approved leave of absence or your coverage has been terminated for less than 90 days, coverage resumes on the date you return to work.
- If you were not on an approved leave of absence or if your coverage has been terminated for more than 90 days, your coverage may not become effective until the pay period following the submission of your request for health benefits.

## OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

### COBRA BENEFITS

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 is 36 months for certain events. Please refer to the COBRA section for more information.

## LINE OF DUTY SURVIVOR COVERAGE UNDER NYC ADMINISTRATIVE CODE SECTION 12.126

New York City Administrative Code provides that surviving spouses/domestic partners and dependents of City employees whose death was the natural and proximate result of an accident or injury sustained while in the performance of duty, or where accidental death benefits have been awarded in connection with a qualifying World Trade Center condition as defined in paragraph (a) of subdivision 36 of section 2 of the retirement and social security law, or where accidental death benefits have been awarded in connection with the death of a City employee as a result of the natural and proximate result of a complication related to the coronavirus disease, COVID-19, shall be afforded the right to City health insurance coverage. To be awarded for accidental death benefits from a NYC pension system as a result of COVID-19, the member's death must have been caused by COVID-19 or where COVID-19 contributed to such member's death, on or before December 31, 2024. Contact the applicable pension plan for information and to obtain the appropriate form to apply.

After you have obtained the accidental death benefits award letter from the deceased member's pension plan, contact the Health Benefits Program, in writing, enclosing a copy of the members' death certificate and the award letter from the pension system. You will receive a Line of Duty Survivor Health Benefits Application. The application needs to be completed and signed by the applicable dependent of the deceased member. Once the Application is completed, please submit it to the Health Benefits Program. Survivors may continue with the same plan they had or choose any other plan for which they are eligible. Please note, if the plan enrolled in has a survivor cost it may be deducted from any pension payment or the survivor will be billed directly for the cost.

## CONTINUATION OF COVERAGE FOR SURVIVING SPOUSE/DOMESTIC PARTNER OF UNIFORM MEMBER (COVERAGE FOR LIFE)

New York City Administrative Code provides that surviving spouses/domestic partners of active and retired uniformed members of the New York City Police, Fire Departments, and the Departments of Sanitation and Corrections can continue their health benefits coverage for life. Such coverage will be at a premium of 102% of the group rate and must be elected within one (1) year of the date of the death of the member. Contact the Health Benefits Program, in writing, enclose a copy of the members' death certificate and you will receive a Coverage for Life Application. The application needs to be completed and signed by the applicable dependent of the deceased member. Once the application is complete it must be sent to the Health Plan. The Health Plan will send you a bill for the monthly premium.

## PROVISIONS FOR MEDICARE-ELIGIBLE EMPLOYEES - AGE 65 AND OVER

### EMPLOYEES AGE 65 AND OVER

Federal law requires the City of New York to offer employees age 65 and over, and their eligible dependents, the same coverage under the same conditions as offered to employees under age 65. The same stipulation applies also to dependents 65 and over. Continuation of primary coverage in the City health plans is automatic (unless waived) and Medicare becomes secondary coverage. Therefore, do not use your Medicare card when you visit your doctor's office. Instead, be sure to use the member ID card provided to you by your current City health plan.

If you are a Medicare-eligible active employee and want Medicare to be your primary coverage, you must waive City health benefits. By doing so, you will not be eligible for the City's group health plan. Contact your agency health benefits or payroll office or NYCAPS