CSA WELFARE FUND PRE-RETIREMENT GUIDE

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The following should serve as a guide to those who are preparing for retirement.

Seek a Pension Consultation

The CSA Union provides financial assistance toward the cost of professional pension consultations. You are strongly advised to see a pension consultant who will help you calculate what your pension will be under the various options that you may wish to consider. The pension consultant should assist you in filing the appropriate papers with the Teacher's Retirement System (TRS) and the Department of Education. The consultant should also assist you in the completion of the application (ERB) for transfer of your City provided Health Benefits from active to retired status and advise you of options available should you have a spouse who has an employer provided health benefits program.

CSA RETIREE WELFARE FUND WWW.CSAWF.ORG

The CSA Retiree Welfare Fund serves as an advocate and a source of assistance in your transfer from active to retiree status. The Fund's office is available to assist you in completing your ERB form to guide you in selecting appropriate coverage and to assist you in conflicts with health plan providers and City agencies. The Retiree Fund also provides substantial health related benefits described later.

IMPORTANT ADVICE:

Stop in at the CSA Retiree Welfare Fund office after filing your retirement papers to have your Welfare Fund benefits activated and your ERB reviewed for accuracy before filing it with the Department of Education. Your ERB should be hand-delivered to Room 101 at 65 Court Street. Do not mail it or give it to your secretary.

Your City Provided Health Benefit Program

The City of New York provides you with ongoing coverage for your City Health Plan into retirement. Coverage by HIP, Blue Cross, GHI, or any other City health plan is transferred from an active to a retiree status when you complete and file the ERB form with the Office of Health and Welfare Benefits at 65 Court Street, room 101. When this form is filed, the City secures your ongoing benefits without interruption.

As an active employee, you are covered for basic hospital and medical coverage without cost for some of the health plans offered. Some plans charge an additional charge for the basic plan. All plans charge for an optional extended coverage rider. The cost of this extended coverage rider is deducted from your payroll check. The cost varies depending upon the health plan selected and whether the plan is an individual or family plan. This cost may be reduced if some of the rider benefits are provided by your union Welfare Fund. For example, the CSA Welfare Fund provides all of its members enrolled in GHI with extended hospitalization and prescription drug coverage. These costs are, therefore, carved out of the member's rider costs and CSA members pay far less for the GHI extended coverage rider than an employee whose welfare fund does not provide these services. When you retire, these reductions, or "carve outs", of your rider costs, will no longer be in effect. Retirees will, therefore, see an increase in their deductions from their pension check for these services since the member will now be paying for prescription drug coverage. The CSA Retiree Welfare Fund will, however, continue to pick up the cost of the extended hospitalization rider.

A detailed description of the optional benefits and their costs can be found in the back of your copy of the "New **York City Health Benefits Program Description**" booklet. It is important that you request the optional benefits rider at retirement to insure that you have prescription drug coverage during retirement, unless you have other drug coverage available to you.

A copy of your New York City Health Benefits Program can be downloaded from the Web site maintained by the New York City Office of Labor Relations at **http://www.nyc.gov/html/olr/html/home/home.shtml**

The cost to a member enrolled in the GHI medical plan, after satisfaction of the $150 annual deductible, is 20% for generic drugs, 40% for brand name and 50% for certain non-formulary drugs. Enrollees requiring long term drug treatment for chronic conditions can obtain a two-month supply of drugs with no deductible. There is a copay ranging from $10 to $60 depending upon the drug dispensed being a generic, brand name, formulary or non-formulary drug.

A similar situation exists for those members who are enrolled in HIP/HMO or any of the other HMO plans available to retirees. Members enrolled in an HMO should be certain to request the optional benefits rider to be covered for prescription drugs.

Your Welfare Fund Benefit Program

CSA retirees have a separate and distinct welfare fund (the CSA Retiree Welfare Fund) which provides retirees with benefits. These benefits are completely different from the benefits received by active employees from the CSA Welfare Fund. Although both the active and retiree Funds are administered centrally, each Fund has its own Board of Trustees, budget and benefit program.

Currently, the CSA Retiree Welfare Fund provides dental, optical, hearing aid, and survivor benefits to retirees and their eligible dependents. The Fund also provides supplemental medical benefits for such services as physical and speech therapy, orthotics, wigs required because of chemotherapy, excess ambulance charges, prescription drug co-payment charges, excess costs for surgery, anesthesia and invasive exams such as colonoscopies, private duty nursing, chemotherapy and radiation treatment. A Stop-Loss Catastrophic medical benefit has been implemented which includes coverage for out of pocket expenses not fully covered by the City Basic Health plan such as office visits and lab charges; after satisfaction of a $1,000 annual deductible, up to a maximum reimbursement of $50,000 annually. Home Health Care benefits have also been added to the CSA Retiree Welfare Fund benefit program. Detailed descriptions of these benefits and their limitations are found in the CSA Retiree Welfare Fund Benefit Booklet provided to each retiree.

Coverage for your Welfare Fund benefits, as a retiree, is linked to the TRS pension program. The City pays the CSA Retiree Welfare Fund to provide you with your welfare fund benefits through the same system that generates your pension checks. Since your initial pension checks may be delayed for several months, the CSA Retiree Welfare Fund will have no record of your eligibility for benefits nor will the Fund receive funding to provide you with benefits. In order to obtain immediate coverage from the Fund, you must file evidence of your pension payability date with the Fund by presenting your TRS filing receipt.

Additional Coverage

Continued CSA Union Membership

As a retired CSA member, you have a right to continued membership in CSA including the right to elect CSA officers and representatives to the CSA governing bodies and continued membership in the American Federation of School Administrators (AFSA) AFLCIO and the New York State Federation of School Administrators (NYFSA). Membership assures you a voice in City, State and Federal issues of concern to you. Membership in the CSA Retiree Chapter will also provide you with a host of additional health benefits supplemental to your Retiree Welfare Fund benefits and National AFL CIO and State benefit programs. Membership in the CSA Retiree Chapter is obtained by filing a dues check off authorization form.

Retirees Enrolled in Medicare

Retirees who are enrolled in Medicare are advised that the GHI-CBP program offers senior care protection, supplemental to Medicare, for members covered by Medicare as well as providing full comprehensive primary coverage for a spouse or other eligible dependent not covered by Medicare.

Retirees covered by the other HMO plans such HIP/HMO are fairly well protected by the comprehensive coverage available under these plans in conjunction with Medicare. The extended coverage riders provide for prescription drugs, nursing and other non-medicare covered services.

Long Term Care

No plan offered by the City or Medicare adequately provides for long term care or custodial care. It is, therefore, recommended that members consider additional coverage in this area such as the CSA endorsed Long Term Care Programs. There are excellent comprehensive Long Term Care Plans available but they are expensive. Members who are interested should contact Doug Hathaway for referral to an agent providing discounts.

In summation - stay healthy, enjoy retirement and if you need assistance, call your representative at the CSA Retiree Chapter at 212-823-2020 or the CSA Retiree Welfare Fund. (212) 962-6061.

SUBMITTING RETIREMENT PAPERS ON-LINE TO TRS

You can complete and file an online version of your service retirement application through TRS's website. TRS is not requiring the application be notarized. When you log onto your website you must go through a validation process for verification purposes. This will be used in place of the notarization requirement.

TRS is strongly discouraging you from mailing documentation and forms to TRS. They have established an e-fax telephone number (212-918-9253) where you can submit all documentation and forms. TRS will then send the documents or forms to your file for processing. Once you have submitted the forms, you will get a general receipt. This is NOT the receipt you submit to the DOE for the continuance of your health care.

You will receive a call from an individual in the TRS unit who processes the retirement applications that they received your papers through the online process. At that point, a retirement receipt will be e-mailed to the member. The call will occur a few days from the date when the member filed the retirement application. This receipt is very important. It needs to accompany your health form that is sent to the DOE so that your health benefits continue once you retire as well as to the welfare fund for activation of retiree Welfare Fund Benefits.

THE LINK FOR SUBMITTING DOCUMENTS ON-LINE IS

HTTPS://TRSNYC.ORG/MEMBERPORTAL/FAQS/FAQINSERVICEMEMBER

Submitting Health Benefits Applications Electronically

Those active, in-service Department of Education participants who plan to retire this spring and summer are required to do so electronically. There is no provision for in-person, face-to-face submission of documents at this time.

The first step in retiring is to submit documents to the Teacher's Retirement System, TRS, to apply for your pension. Please follow the procedures in the posting "A Message to Members Retiring Within 90 Days" located on the CSA website, www.csa-nyc.org.

When TRS accepts your documents, they will email you a "TRS Receipt" showing your name and date of retirement. **THIS DOCUMENT IS REQURIED WHEN APPLYING FOR HEALTH BENEFITS AND WELFARE FUND BENEFITS**.

You must file a **Health Benefits Application** form and copy of the TRS Receipt to continue health benefits as a retiree.

You must file a **CSA RETIREE WELFARE FUND EMROLLMENT FORM** and copy of the TRS Receipt to obtain Retiree Welfare Fund Benefits.

These forms available on the Welfare Fund Website, www.csawf.org.

Please complete both forms and email each, with a copy of your TRS Receipt to enrollment@csawf.org for review. In "normal times" we ask that you stop by so we can review the documents, and will perform the same service electronically and notify you when all is correct.

Once the documents have been reviewed, please email the **TRS Receipt** and H**ealth Benefits Application** to the Department of Education health and Welfare office at HRConnectbenefax@schools.nyc.gov.

TEACHERS' RETIREMENT SYSTEM OF THE CITY OF NEW YORK
55 Water Street, New York, NY 10041 • www.trsnyc.org • 1 (888) 8-NYC-TRS

RECEIPT—SERVICE RETIREMENT APPLICATION

Date: April 23, 2020
Inquiry Number:
TRS Membership Number

Received from Member

QPP Loan Direct Rollover Election Form

QPP Loan Application

TDA Deferral Status Election Form for Retiring Members

Retirement Date 07/01/2020

You may use this receipt as confirmation of your retirement filing when applying for health insurance. Department of Education employees should submit a copy of this receipt to the Department of Education, 65 Court Street, Room 101, Brooklyn, NY 11201; Charter School and City University of New York employees should submit a copy of this receipt to their employer's personnel office.

Please note that members may change their retirement payment option no later than 30 days following their retirement date or, if applicable, the deferred payability date of their retirement allowance.

Member Services Representative
Vilma Duncan

Please keep this receipt for your records. Also, please note that this receipt does not confirm that TRS' review of your retirement application has been completed or that your eligibility for a service retirement has been confirmed. If you require additional assistance, please contact our Member Services Center at 1 (888) 8-NYC-TRS. When you contact TRS, please refer to the Inquiry Number above.

(MS10)

Health Benefits Program
Application/Change Form

www.nyc.gov/olr

Employees Return Form to:	Retirees (212) 513-0470 Return Form to:	For Domestic Partner Changes - Return Form to:
Your Agency's Payroll or Personnel Office	**Health Benefits Program** 22 Cortlandt Street - 12th Fl. New York, NY 10007 FAX: (212) 306-7756	**Health Benefits Program** 22 Cortlandt Street - 12th Fl. New York, NY 10007 Attn: Domestic Partner Unit

Please print all information clearly using a black or blue ballpoint pen.

Applicant MUST check one: ❑ **EMPLOYEE** ❑ **RETIREE** ❑ **RETURN TO RETIREMENT (Check this box if you were previously retired)** ❑ **LINE OF DUTY SURVIVOR**

REASON(S) FOR SUBMISSION (Check one or more boxes. Enter change date, if appropriate)

A.
- ❑ New Enrollment
- ❑ Reinstatement*
- ❑ Retirement
- ❑ Disability Retirement*
- ❑ Accident Disability Retirement
- ❑ Drop Optional Benefits*
- ❑ Add Optional Benefits*
- ❑ Waive Benefits*

EMPLOYEES ONLY:
- ❑ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H

*Please indicate Effective Date: ________________

B. Change of:
- ❑ Spouse/Domestic Partner: ❑Add ❑Drop
  Effective Date: ______/______/______
- ❑ Dependent Child(ren): ❑Add ❑Drop
  Effective Date: ______/______/______
- ❑ Change of Name - Former Name: ______________________________

C. Transfer of Health Plan and/or Optional/Benefit Based on:
- ❑ Transfer Period
- ❑ Move Into/Out of Health Plan Area
  Effective Date: ______/______/______
- ❑ Retiree Once-in-A-Lifetime
  Effective Date: ______/______/______

D. EMPLOYEE/RETIREE INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:

Home Address:	Apt.:

City:	State:	Zip Code:	Country (if outside the U.S.):

Date of Birth:	Sex: ❑M ❑F	Work - Telephone Number:	Mobile\Home - Telephone Number:	E-mail Address:

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic Partnership	Date of Event (MM/DD/YY)	Agency in which employed or retired from:	Union or Welfare Fund:

Name of current City Health Plan:	Are you Medicare eligible: ❑Yes ❑No If YES, please attach a copy of your Medicare card to this application.	*ATTACH COPY OF CARD*

E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

Last Name:	First Name:	M.I.:	Social Security Number:	Date of Birth:

Sex: ❑M ❑F

Is spouse/domestic partner: ❑Employed (**Double City coverage is not permitted**) ❑Retired (**Double City coverage is not permitted**) ❑Not Employed ❑City Agency Name:______________________ ❑Non-City Related

Does spouse/domestic partner have Non-City group health plan? ❑Yes ❑No	Is your spouse/domestic partner Medicare eligible: ❑Yes ❑No If YES, please attach a copy of his/her Medicare card to this application.	*ATTACH COPY OF CARD*

F. FAMILY INFORMATION (Attach a second form if necessary; dependent may not be covered under two NYC Health Plans.)

List all eligible dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below.
(CUNY ADJUNCT EMPLOYEES: CITY RATES APPLY FOR INDIVIDUAL COVERAGE *ONLY*. CONTACT YOUR BENEFITS OFFICE FOR INFORMATION ABOUT ADDITIONAL COST FOR FAMILY COVERAGE.)

*Attach a copy of Medicare card if disabled dependent is Medicare eligible.

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex: M/F	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑

G. HEALTH PLAN REQUESTED (Please print clearly)

FULL NAME OF HEALTH PLAN SELECTED: ______________________________

Optional Benefits? (Check "Yes" or "No" for optional benefits rider. If no box is checked, it will be presumed that you do not want optional benefits.) ❑Yes ❑No

H. EMPLOYEES ONLY (RETIREES ARE INELIGIBLE FOR THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM)

I wish to participate in the Health Benefits Buy-Out Waiver Program. I have read the Medical Spending Conversion Health Benefits Buy-Out Waiver Program brochure and completed a Medical Spending Conversion Form and I attest that I meet the qualifications for this program. (Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible.)

Employee Signature: Date:

I. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR REQUEST CHANGES TO HEALTH COVERAGE

I certify that the above information is correct and I authorize the City to deduct from my salary/pension the amount required, if any, through the City Health Benefits Program.

I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that my periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code 125. I understand that I have an option to decline this benefit, by obtaining a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits Box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

Employee/Retiree Signature: Date:

J. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures. I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Buy-Out Spending Form and I attest that the employee meets the qualifications for this Program.

Agency Code:	Title Code No.:	Status: ❑ Full-Time ❑ Part-Time ❑ Permanent ❑ Provisional	Appointment/Retirement Date: / /	Pay Period: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Semi-Monthly	Effective Date of Coverage: / /

Retirement System (For Retiring Employees):	Years of Credited Service:	City Start Date: / /	Retirement Date: / /	Pension Number:

Certifying Signature:	Date: / /	Telephone Number: ( ) -

Instructions for Completing a Health Benefits Application/Change Form

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement or Waive Benefits.

If you are already covered as a retiree, you should only select from the following: Drop/Add Optional Benefits, Waive Benefits (if you wish to cancel your City coverage) and Reinstatement (if you are requesting to reinstate your City coverage after having previously waived coverage).

Section B: Check Spouse/Domestic Partner Information (Add/Drop) if you are adding or dropping a spouse/domestic partner.

If your spouse/domestic partner is deceased, you must attach a copy of the death certificate. If you are dropping your spouse as a result of a divorce, you must attach a copy of the divorce decree.

If you are adding a spouse, domestic partner or dependent child(ren) please refer to the SPD or the Dependent Eligibility Required Documentation instructions on our Web site, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

Check Dependent Child(ren) Add or Drop if you are adding or dropping a dependent child. If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.

If changing your name, please indicate your former name and provide documentation of name change.

Section C: Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Transfer Period.

Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.

Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.

Section D: If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.

Section E: If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.

If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.

If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

Section F: List **ALL** eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. (CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. **Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible for the** Buy-Out Wavier Program.

Section I: Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.

Section J: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form.
Retain a copy for your records.

Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire Blue Access Gated EPO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP Prime HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Health Plans Available to
Medicare-Eligible Retirees and their Dependents

Aetna Medicare PPO ESA Plan*
AvMed Medicare HMO* (Florida only)
Cigna HealthSpring Preferred with Rx (HMO)* (Arizona only)
DC 37 Med-Team Senior Plan (DC 37 Members Only)
Elderplan*
Empire Medicare Related Coverage
Empire MediBlue Freedom (PPO)*
GHI/Empire BlueCross BlueShield Senior Care
GHI HMO Medicare Senior Supplement
HIP VIP Premier (HMO) Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
UnitedHealthcare Group Medicare Advantage Plan*

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

* Medicare eligible retirees who wish to enroll in these plans must enroll DIRECTLY with the health plan. Please verify with the health plan of your choice whether or not you reside in its service area. Do not use this form for enrollment in these plans.

OFFICE USE ONLY

EFFECTIVE DATE ______________________

ID # ______________________

CSA RETIREE WELFARE FUND

ENROLLMENT CARD

OFFICE USE ONLY

MAIN MENU ______________________

DENTAL ______________________

SOC. SEC. NO. ________________________________ **PENSION #** __________________ **DATE OF BIRTH: Month** _____ **Day** ____ **Year** _________

(Print) Last Name ____ **First Name** ______________________________ **Middle Initial** _________

Home Address ____ **City** __________________________________ **State** _____ **Zip** _____________

Home Tel.# (_____) ______________________ **Email Address** ____ **Last Position :** ________________________________

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Male ☐ **Female** ☐ **Single** ☐ **Married** ☐ **Domestic Partner** ☐ **Widowed** ☐ **Divorced** ☐

Date of Marriage or Dom. Ptnr. Certification	Month	Day	Year

My City Basic Plan is (Check one) HIP ☐ **GHI-CBP** ☐ **Other** ☐ ______________________________

Spouse/Domestic Partner's Soc. Sec. # ________________________ **Is Spouse/Dom. Ptnr. employed? Yes** ☐ **No** ☐ **Retired? Yes** ☐ **No** ☐

Name of Spouse/domestic partner's Employer or Retired from: ____

Is Group Insurance Available from Spouse/Dom. Ptnr's Employer/retirement? Yes ☐ **No** ☐ **If Yes, Check Coverage Provided : Dental** ☐ **Hospital** ☐ **Medical** ☐ **Optical** ☐ **Drugs** ☐

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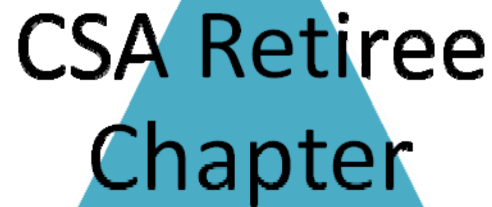
List Below all Dependents eligible for coverage:	Wife	Husband	Dom. Ptnr.	Son	Daughter	Date of Birth	Social SecurityNumber
1.							
2.							
3.							
4.							
5.							

Signature of Member ____ **Date Card is Signed** ______________________________

Your Retiree Health Coverage

(For Non-Medicare Eligible Members)



CSA
RetireeWelfare
Fund

City Provided Health
Plan

RETIREE Health Plan Rates as of January 1, 2021

These rates will be reflected in your January 2021 pension check

PLEASE NOTE THAT ALL RATES ARE SUBJECT TO CHANGE

MONTHLY NON-MEDICARE

INDIVIDUAL	Aetna EPO	CIGNA	DC37 Med-Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan (Grandfathered)	HIP HMO Gold Preferred Plan Optional Standard	HIP Prime POS	MetroPlus Gold	Vytra
Basic	$368.92	$1,033.48	$0.00	$319.58	$1,072.54	$0.00	$220.08	$0.00	$0.00	$1,222.54	$0.00	$174.31
Prescription Drugs	$1,835.75	$308.89	$0.00	$271.24	$271.24	$79.20	$403.45	$290.40	$132.23	$338.34	$230.61	$341.89
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$4.71	$0.00	$8.55	$8.55	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$2,204.67**	**$1,342.37**	**$0.00**	**$590.82**	**$1,343.78**	**$83.91**	**$623.53**	**$298.95**	**$140.78**	**$1,560.88**	**$230.61**	**$516.20**
FAMILY	**Aetna EPO**	**CIGNA**	**DC37 Med-Team**	**Empire Blue Access Gated EPO**	**Empire EPO**	**GHI-CBP/EBCBS**	**GHI HMO**	**HIP HMO Gold Preferred Plan (Grandfathered)**	**HIP HMO Gold Preferred Plan Optional Standard**	**HIP Prime POS**	**MetroPlus Gold**	**Vytra**
Basic	$1,545.42	$2,778.07	$0.00	$947.01	$2,720.80	$0.00	$637.68	$0.00	$0.00	$2,995.23	$0.00	$600.09
Prescription Drugs	$5,192.13	$934.63	$0.00	$664.97	$664.97	$140.77	$1,028.76	$711.48	$242.43	$828.94	$520.03	$889.18
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$11.92	$0.00	$20.96	$20.96	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$6,737.55**	**$3,712.70**	**$0.00**	**$1,611.98**	**$3,385.77**	**$152.69**	**$1,666.44**	**$732.44**	**$263.39**	**$3,824.17**	**$520.03**	**$1,489.27**

*** For GHI-CBP/EBCBS, "Rider Other" is for enhanced major medical coverage. For HIP HMO, "Rider Other" is for private duty nursing & durable medical equipment.**

MONTHLY MEDICARE

INDIVIDUAL	Aetna Medicare Advantage Plan PPO/ESA (NY/NJ/PA)	Aetna Medicare Advantage Plan PPO/ESA (All Other Areas)	CIGNA Healthspring (AZ)	DC37 Med-Team Senior Care	Empire Medicare Related	Empire MediBlue Freedom (PPO)	GHI Senior Care	GHI HMO Medicare Senior Supplement	HIP VIP Premier (HMO)	Humana Gold Plus	United Healtcare Group Medicare Advantage Plan Horizons (NYC)	United Healtcare Group Medicare Advantage Plan Horizons (NJ)
Basic	$139.45	$0.00	$109.35	$0.00	$103.96	$0.00	$0.00	$518.35	$0.00	$0.00	$137.44	$87.78
Prescription Drugs	$192.50	$192.50	$0.00	$0.00	$204.70	$132.76	$150.30	$85.00	$177.59	$37.24	$84.58	$128.11
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$331.95**	**$192.50**	**$109.35**	**$0.00**	**$308.66**	**$132.76**	**$151.30**	**$603.35**	**$177.59**	**$37.24**	**$222.02**	**$215.89**
FAMILY	**Aetna Medicare Advantage Plan PPO/ESA (NY/NJ/PA)**	**Aetna Medicare Advantage Plan PPO/ESA (All Other Areas)**	**CIGNA Healthspring (AZ)**	**DC37 Med-Team Senior Care**	**Empire Medicare Related**	**Empire MediBlue Freedom (PPO)**	**GHI Senior Care**	**GHI HMO Medicare Senior Supplement**	**HIP VIP Premier (HMO)**	**Humana Gold Plus**	**United Healtcare Group Medicare Advantage Plan Horizons (NYC)**	**United Healtcare Group Medicare Advantage Plan Horizons (NJ)**
Basic	$278.90	$0.00	$218.70	$0.00	$200.97	$0.00	$0.00	$1,036.70	$0.00	$0.00	$274.88	$175.56
Prescription Drugs	$385.00	$385.00	$0.00	$0.00	$409.40	$265.52	$300.60	$170.00	$355.18	$74.48	$169.16	$256.22
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$663.90**	**$385.00**	**$218.70**	**$0.00**	**$610.37**	**$265.52**	**$302.60**	**$1,206.70**	**$355.18**	**$74.48**	**$444.04**	**$431.78**

*** For GHI Senior Care, "Rider Other" is for 365-Day Hospitalization.**

NOTE: AvMed, BC Health Options & ElderPlan are "zero" premium plans.

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 qualifications for eligibility for health benefits at retirement?

a. You have, at the time of retirement, 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 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.

EXCEPTIONS: Members of pension systems not maintained by the City may be eligible for health coverage pursuant to legislation or a collective bargaining agreement specifying such 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 22 Cortlandt Street, 12th Floor, NY, NY 10007, 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, pleased 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 **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct 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

LONG TERM CARE: THE INSURANCE COVERAGE YOU WISH YOU COULD DO WITHOUT

By: Douglas V. Hathaway, Ph.D.
Administrator, CSA Welfare Funds

In my discussions with members, both active and retired, the one major concern that comes up more than any other is that of the prospect of spending the last years of life in a nursing home. Most people would prefer staying at home in more familiar, less threatening surroundings, under the care of a professional home health aide. No one I know looks forward to either situation but all are concerned that the cost of such care - either at home or in a facility - will drain away whatever financial security they have built for themselves and their loved ones. Unfortunately, many people prefer to ignore this emotionally troubling matter. My advice is that it is far wiser to confront this issue head on and consider the purchase of Long Term Care insurance to provide you and your family with peace of mind.

Nursing home or home health care frequently referred to as "custodial care" is not covered by Medicare or basic health plans. Most health plans, including Medicare, provide for limited coverage in a skilled nursing facility or rehabilitation center. Such coverage is limited and designed for short stays in rehabilitation centers and skilled nursing facilities following hospitalization as an extension of care. This is not custodial care.

CSA retirees have some limited coverage for home care by the CSA Retiree Welfare Fund. Such coverage is designed for temporary care, primarily for members or dependents that need some custodial assistance following hospitalization. This coverage is limited to $10,000 a year to a maximum of $30,000 lifetime. It is not long term care. Retirees who are members of the CSA Retiree Chapter receive additional reimbursement, currently 20% of the Retiree Welfare Fund reimbursement.

Some members who purchased a catastrophic health plan from U.S. Life Insurance Company through Seabury & Smith (formerly Albert H. Wolhers' Company) of the Marsh Affinity Group are under the mistaken impression that they have long term care coverage. The Two Million Dollar Catastrophic Medical Plan does provide for nursing home or home care but the coverage is very limited. It is, therefore, not a long term care plan.

Long Term Care insurance is not necessary for people with limited income since such people should be able to qualify for Medicaid benefits. For our members who can expect a retirement income far in excess of Medicaid eligibility, long term care insurance is the only way to protect assets.

People buy Long Term Care Insurance because they don't want to be dependent on anyone for their care. They don't want to be a burden to family or friends. In many cases, adult children have paid premiums for parents who can't afford the insurance in order to protect themselves financially while insuring that their parents get adequate care without becoming a burden on the family.

There are many policies being offered with varying designs which can be adjusted for waiting periods, maximum daily limits and duration of coverage. These factors are what determine premium costs. Benefits start when certain criteria are met, criteria such as a

person's inability to perform two or more activities of daily living such as bathing, dressing, transferring, toileting, bladder control or eating without needing assistance. There are also criteria for cognitive impairment, such as Alzheimer's disease, which can trigger a claim. Premiums are significant but are fixed at the age of purchase. Therefore, they are less expensive for people in their 50's than for those in their 60's. Inflation protection is quite important. A policy bought at age 65 may not provide adequate coverage at 85 because of cost of living increases. Since not all policies contain inflation protection, it is important that you are cognizant of this aspect of Long Term Care insurance.

It is also very important to price shop and compare before you buy a Long Term Care plan. Insurance companies offering this coverage differ in their criteria for eligibility, levels of coverage and premiums. Different companies offer different unique features and each company may offer a variety of options to be considered. It is, therefore, critical that you compare offerings from more than one insurance company.

Please visit the CSA website, www.csa-nyc.org, and log in to your member section. Follow links to the member benefits and scroll down to Long Term Care to view the policies endorsed by CSA and to schedule an appointment with the CSA representative.

I am a great believer in long term care coverage and urge all active retired members to consider obtaining this protection. I also hope that none of us have to use it.

SURVIVOR'S INFORMATION GUIDE

AS A BENEFIT TO OUR MEMBERSHIP, WE HAVE PREPARED A BROCHURE OF INFORMATION WHICH MAY BE HELPFUL TO FAMILY MEMBERS OF AN INCAPACITATED MEMBER OR A SURVIVING SPOUSE/ DOMESTIC PARTNER OFA DECEASED MEMBER OF THE CSA RETIREE CHAPTER. Make sure that your spouse/domestic partner or the person you designate to handle your affairs is familiar with the contents of the brochure and is aware of its location.

Dealing with the legal ramifications that occur after the loss of a spouse or domestic partner can be difficult or troublesome. We have prepared this list of ***agencies/ organizations that must be notified as soon as possible.*** The more timely the notifications, the smoother the process will be for implementing survivor's benefits.

Teacher's Retirement System of the City of New York
55 Water Street, New York, NY 10041
(888) 8-NYC-TRS (869-2877)
www.trs.nyc.ny.us

1. Ask about benefits that may be coming to the beneficiary.
2. An **original** Death Certificate will be required.
3. The entire check for the month of death must be returned (If direct deposit was used, TRS will get the money from the bank). TRS will issue a pro-rata check for the month.

New York City Department of Labor Relations, Employee Benefits Program
22 Cortlandt Street, 12th Floor
New York, NY 10007
(212) 513-0470
www.nyc.gov/html/olr/html/home/home.shtml

1. An **original** Death Certificate will be required.
2. They will contact current health insurer. Survivor does not need to do so.
3. If the survivor wishes to continue NYC health coverage under **COBRA** (A Federal Law), an application must be made within 60 days of the death of the covered member.

Social Security Administration

(800) 772-1213 (Northeast program center). Check for local center if residing elsewhere.

1. Must call, **IF** the deceased was receiving Social Security and/or Medicare benefits.

www.ssa.gov

CSA Retiree Chapter
40 Rector Street
12th Floor
New York, NY 10006
Tel: (212) 823-2020
www.csa-nyc.org

1. If the surviving spouse/ Registered Domestic Partner were a spousal member, he/she may continue membership with supplemental health benefits for as long as they remain eligible for CSA Retiree Welfare Fund benefits. An application must be completed.
2. If the member was also a member of a CSA Regional Unit, the local representative should be contacted.
3. A copy of the Death Certificate is requested.

CSA Retiree Welfare Fund
40 Rector Street
12th Floor
New York, NY 10006
(212) 962-6061
www.csawf.org

1. Surviving Spouse Benefits continue without cost for 5 years from date of death of the member.
2. Ask for the survivor's information packet.

INFORMATION FOR SURVIVORS OF DECEASED MEMBERS OF THE CSA RETIREE CHAPTER

The following information will be needed to settle my affairs:

1. **Date of Birth_____________Place of Birth______________________________**
2. **Copy of my Birth Certificate is in______________________________________**
3. **My Social Security#____**
4. **My last work site was____**
5. **I retired on (date)____**
6. **My last job title was____**
7. **My Pension#____**
8. **My Pension Option was____**
9. **My TDA#____**
10. **My TDA Beneficiary (ies)____**
11. **My Health Plan____**
12. **My Health Plan ID#____**
13. **My Spouses Health Plan____**
14. **Other organizational benefits (with contact information)**

    a.____
    b.____
    c.____
    d.____

ADDITIONAL INFORMATION

The previous data and contact information is specific to CSA retirees. There are numerous additional items that any survivor needs to access quickly and easily.

1. **The original (official) copy of my will is located**

   at____

   ____

2. **The attorney who has been handling my affairs**

   is____

   Contact____

3. **My tax papers are located at____**

4. **My accountant is____**
   Contact____

5. **I was a war veteran (yes or no)____ If yes, Veterans claim _________________ Contact Regional Office of the Veteran's Administration for New York at (800) 827-1000**

6. **Organizations which may provide a death benefit (list name, address, and phone number).**
   ____
   ____
   ____

7. **ASSETS**
   Bank Accounts- Name and location of bank and type of account
   ____
   ____
   ____
   ____
   ____
   List of accounts and numbers is kept at/ in____
   Safety Deposit Box is located at
   ____
   Key and box number is located at
   ____

List your Investment

Broker(s)____

____

8. INSURANCE

Life insurance policies (contracts) are located at/ in:

____

____

9. CONTACTS

Specify the purpose for making the contract (religious services, burial society, professional service provider who has valuable information, friend/ family member who can contact others or assist in other ways, etc.)

Reason for contact:

____

Name (person and/or organization):

____

Address:____

____

Phone #

____

Reason for contact:

____

Name (person and/or organization):

____

Address:____

____

Phone #

____

Reason for contact:

____

Name (person and/or organization):

____

Address:____

____

Phone #

____

Form Approved
OMB No. 0938-0787
Expires: 06/2023

REQUEST FOR EMPLOYMENT INFORMATION

WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

HOW IS THE FORM COMPLETED?

- Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
- The employer fills in the information in the second section and signs at the bottom.

WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: **www.ssa.gov**.

GET HELP WITH THIS FORM

- **Phone:** Call Social Security at **1-800-772-1213**
- **En español:** Llame a SSA gratis al **1-800-772-1213** y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- **In person:** Your local Social Security office. For an office near you check **www.ssa.gov**.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name
2. Date __ __ / __ __ / __ __ __ __

3. Employer's Address

City
State
Zip Code

4. Applicant's Name
5. Applicant's Social Security Number __ __ __ – __ __ – __ __ __ __

6. Employee's Name
7. Employee's Social Security Number __ __ __ – __ __ – __ __ __ __

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? Yes No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
__ __ / __ __ __ __

3. Has the coverage ended? Yes No

4. If yes, give the date the coverage ended. (mm/yyyy)
__ __ / __ __ __ __

5. When did the employee work for your company?
From: (mm/yyyy) __ __ / __ __ __ __
To: (mm/yyyy) __ __ / __ __ __ __
Still Employed: (mm/yyyy) __ __ / __ __ __ __

6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.
From: (mm/yyyy) __ __ / __ __ __ __
To: (mm/yyyy) __ __ / __ __ __ __

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? Yes No

2. If yes, does the applicant have hours remaining in reserve? Yes No

3. Date reserve hours ended or will be used? (mm/yyyy)
__ __ / __ __ __ __

All Employers:

Signature of Company Official
Date Signed __ __ / __ __ / __ __ __ __

Title of Company Official
Phone Number (__ __ __) __ __ __ – __ __ __ __

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

Form Approved
OMB No. 0938-0787

STEP BY STEP INSTRUCTIONS FOR THIS FORM

SECTION A:
The person applying for Medicare completes all of Section A.

1. **Employer's name:**
   Write the name of your employer.
2. **Date:**
   Write the date that you're filling out the Request for Employment Information form.
3. **Employer's address:**
   Write your employer's address.
4. **Applicant's Name:**
   Write your name here.
5. **Applicant's Social Security Number:**
   Write your Social Security Number here.
6. **Employee's Name:**
   If you get group health plan coverage based on your employment, write your name here. If you get group health plan coverage through another person, like a spouse or family member, write their name.
7. **Employee's Social Security Number:**
   If you get group health plan coverage based on your employment, write your Social Security Number here. If you get group health plan coverage through another person, like a spouse or family member, write their Social Security Number.

Once you complete Section A:

Once Section A is completed, give this form to your employer to complete Section B. Once Section B has been completed by your employer, return this form along with your Part B application to your local Social Security office.

SECTION B:
The employer completes all of Section B.

If you're an employer without an hours bank arrangement, complete the section called "For Employer Group Health Plans ONLY"

1. **Is (or was) the applicant covered under an employer group health plan?**
   Please check yes or no if the applicant was covered under your group health plan offered by your company. The applicant may be the employee or another person related to the employee, such as a spouse or family member with disabilities. If your company doesn't offer a group health plan, please check No. A group health plan is any plan of one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families.
2. **If yes, give the date the coverage began.**
   Write the month and year the date the applicant's coverage began in your group health plan.
3. **Has the coverage ended?**
   Check yes or no if the group health plan coverage for the applicant has ended.
4. **If yes, give the date the coverage ended.**
   Write the month and year the group health plan coverage ended for the applicant.
5. **When did the employee work for your company?**
   Write the start and end dates of the employment for the employee in which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse or family member with disabilities.

   Enter the month and year of the start of the employment in the "From" box.

   Enter the month and year of end of the employment in the "To" box.

   If the employee is still employed, enter the month and year of the current date.

   Current employment is active working status. It is not disability or retirement.
6. **If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.**
   Write the start and end dates that your group health plan was primary payer for the applicant.

If you're an employer with an hours bank arrangement, complete the section called "For Hours Bank Arrangements ONLY"

1. **Is (or was) the applicant covered under an hours bank arrangement?**
   Please check yes or no if the applicant was covered under an hours bank arrangement. If you check no, please also fill out the section for "Employer Group Health Plans ONLY".
2. **If yes, does the applicant have hours remaining in reserve?**
   Please indicate if the applicant currently has health coverage based on the remaining hours in the employee's hours bank account.
3. **Date reserve hours ended or will be used?**
   Please write the month and year for when the remaining hours in the employee's hours bank account expired or will expire.

All employers need to complete the bottom of Section B.

- **Signature of Company Official:**
  An official representative of the company needs to sign this document. Please do not print.
- **Date Signed:**
  Write the date that you sign the form in this field.
- **Title of Company Official:**
  Print the title of the company official who signed the form in this field.
- **Phone Number:**
  Write the phone number of the company official who signed the form in this field. If there are questions regarding the information on this form, a representative from Social Security will contact you.

BENEFIT	CSA RETIREE WELFARE FUND	CSA RETIREE CHAPTER**
DENTAL PROGRAM	CHOICE OF FOUR PLANS OFFERED: SIDS (SCHEDULE PLAN); DENTCARE (HMO) AMERICAN DENTAL OF FLORIDA (HMO) OR DELTA DENTAL (HMO)	UNDER DEVELOPMENT
OPTICAL PROGRAM	1 CERTIFICATE EVERY 12 MONTHS ***Effective Jan. 1, 2016*** $100 REIMBURSEMENT DIRECT TO PARTICIPANT VISUAL AID MACHINE ($500 MAX-ONCE IN A LIFETIME) LASER VISION CORRECTION $500 (ONCE IN A LIFETIME) MULTI-FOCAL LENS FOLLOWING CATARACT SURGERY - $ 500 PER EYE (ONCE IN A LIFETIME)	***EFFECTIVE JANUARY 1, 2018***: SUPPLEMENTAL TO WELFARE FUND – UP TO $65 PER YEAR FOR MEMBER AND COVERED SPOUSE
HEARING AID PROGRAM	***Effective Jan. 1, 2014*** - $800 ONCE EVERY 3 YEARS -	***EFFECTIVE JANUARY 1, 2012***: SUPPLEMENTAL TO WELFARE FUND UP TO $800 EVERY 3 YEARS
HOME HEALTH AIDE CARE	**EFFECTIVE 1/2019** – COVERAGE PROVIDED FOR POST HOSPITALIZATION HOME HEALTH CARE. PHYSICIAN CERTIFICATION REQUIRED TO PROVIDE COVERAGE BY CERTIFIED HOME HEALTH AIDE. AFTER $100 ANNUAL DEDUCTIBLE, COVERAGE =80% TO ANNUAL MAX OF $10,000 LIFETIME LIMIT=$30,000	SUPPLEMENTAL TO WELFARE FUND = 20% OF PAYMENT OF WELFARE FUND PAYMENT NO DEDUCTIBLE/NO CO-PAY/NO MAXIMUM
CATASTROPHIC /STOP LOSS COVERAGE	EFFECTIVE 1/2005 REIMBURSEMENT OF MEDICAL EXPENSES FOR ALL OUT OF POCKET EXPENSES NOT FULLY COVERED BY CITY BASIC HEALTH PLAN INCLUDING OFFICE VISITS, LAB CHARGES ETC. PROVIDED BASIC PLAN COVERS THESE SERVICES AFTER $1,000 DEDUCTIBLE, FUND REIMBURSES 80% OF ADDITIONAL EXPENSES TO $1,000 IN PAYMENT, THEREAFTER, AT 100% TO $50,000 ANNUALLY / $250,000 LIFETIME MAX	SUPPLEMENTAL TO WELFARE FUND ADDITIONAL 20% OF WELFARE FUND PAYMENT. NO DEDUCTIBLE/NO CO-PAY/NO MAXIMUM
RX CO-PAY REIMBURSEMENT FOR NON-MEDICARE/GHI RETIREES AND HMO RETIREES	EFFECTIVE 2006 RX CO-PAY REIMBURSEMENT = SUBJECT TO $100 DEDUCTIBLE / PAYABLE @ 80% / MAX=$10,000	SUPPLEMENTAL TO WELFARE FUND ADDITIONAL 20% OF FUND PAYMENT
RX CO-PAY REIMBURSEMENT FOR GHI MEDICARE ELIGIBLE RETIREES W/CITY PLAN & RIDER	FOR **2021 =** AFTER MEETING **$6,550** TROOP EXPENSE– REIMBURSEMENT OF CO-PAYS = NO DEDUCTIBLE/ PAYABLE @100%/ MAX=$5,000 For **2020 =** AFTER MEETING **$6,350** TROOP EXPENSE, **2018** Troop = **$ 5,100**	N/A
RX CO-PAY REIMBURSEMENT FOR MEDICARE ELIGIBLE SURVIVING SPOUSES	SURVIVING SPOUSES COVERED BY A CITY PLAN THROUGH COBRA/or OWN HEALTH PLAN W/RX COVERAGE = RX CO-PAY REIMBURSEMENT= $100 DEDUCTIBLE /@ 80% / MAX = $5,000	SUPPLEMENTAL TO WELFARE FUND = 20% OF FUND PAYMENT

****ELIGIBILITY FOR RETIREE CHAPTER SUPPLEMENTAL BENEFITS:**

Enrollees must join within 12 months of their retirement date. Anyone joining after the 12 month enrollment period may not claim Retiree Chapter supplemental health benefits for 18 months from the enrollment date.

(Surviving spouses must join within 6 months of the member's death)

BENEFIT	CSA RETIREE WELFARE FUND	CSA RETIREE CHAPTER
SUPPLEMENTAL MEDICAL PROGRAM	REIMBURSEMENT @80% OF COSTS AFTER $100 ANNUAL DEDUCTIBLE REIMBURSEMENT OF EXPENSES SUPPLEMENTAL TO COVERAGE PROVIDED BY GHI OR HMO FOR ALL OF BELOW LISTED SERVICES SURGERY / ANESTHESIA / DIAGNOSTIC INVASIVE PROCEDURES SUCH AS COLONOSCOPIES AND BRONCHOSCOPIES PRIVATE DUTY NURSING (Separate $ 10,000 Max) RADIATION & CHEMOTHERAPY COSTS EXCLUSIVE OF DRUGS EMERGENCY AMBULANCE NOT FULLY COVERED BY BASIC CITY PLAN / NON-EMERGENCY AMBULANCE OR AMBULETTE SERVICES BY REVIEW ($ 2,500 Max) WIGS FOR CANCER TREATMENT OR ALOPECIA ($1,000 MAX PER YEAR) SURGICAL STOCKINGS(3 PR. YEAR MAX) EFF: 1/1/05 =($150 ANNUAL MAX) REMOVABLE OR PORTABLE TOILET SEAT (1 PER YR/$100 MAX) ORTHOTICS (MAX=$400 per pair, 2 pair maximum – total $800) PHYSICAL, SPEECH, OCCUPATIONAL THERAPY & COUNSELING – UP TO $2,000 REIMBURSEMENT AFTER PRIMARY BENEFIT EXHUSTED (**eff. 1/2015**) ACUPUNCTURE – UP TO 36 VISITS PER YEAR BY LICENSED PROVIDER, MAX ALLOWABLE CHARGE $100 PER VISIT $300 HOSPITAL DEDUCTIBLE (MAX=$750) HMO OFFICE VISIT COPAYS REIMBURSEMENT	ALL COVERAGE SUPPLEMENTAL TO WELFARE FUND COVERAGE. PAYMENT UP TO 20% OF FUND COVERAGE UNLESS OTHERWISE STATED. NO DEDUCTIBLE/NO CO-PAYS/NO MAXIMUM FOR ALL OF BELOW LISTED SERVICES SUPPLEMENTAL TO W.F. - 20% OF FUND PAYMENT SUPPLEMENTAL TO WELFARE FUND - 20% OF FUND PAYMENT SUPPLEMENTAL TO WELFARE FUND - 20% OF FUND PAYMENT N/A (COST INCLUDED IN CATASTROPHIC BENEFIT) N/A (COST INCLUDED IN CATASTROPHIC BENEFIT) N/A (COST INCLUDED IN CATASTROPHIC BENEFIT) N/A (COST INCLUDED IN CATASTROPHIC BENEFIT) N/A (COST INCLUDED IN CATASTROPHIC BENEFIT) SUPPLEMENTAL TO WELFARE FUND - 20% OF FUND PAYMENT
EXTENDED HOSPITALIZATION	THE CITY HEALTH PLAN COVERAGE FOR GHI-CBP/EBCBS PROVIDES COVERAGE OF 365 FULL DAYS OF HOSPITALIZATION FOR NON-MEDICARE ELGIBLE MEMBERS FOR MEDICARE ELIGIBLE = EXTENDED COVERAGE TO 365 DAYS IS PROVIDED ONLY THROUGH THE OPTIONAL BENEFITS RIDER. HOWEVER, CSA PICKS UP THE COST FOR THIS EXTENDED HOSPITALIZATION COVERAGE EVEN IF RIDER IS NOT SELECTED	COVERED BY CSA RIDER
SURVIVOR BENEFITS	ELIGIBLE DEPENDENT SURVIVORS COVERED BY FUND FOR 5 YEARS AFTER DEATH OF MEMBER AT NO COST THEREAFTER, COVERAGE AT COBRA RATE WITHOUT TIME LIMITATION	SURVIVING SPOUSE MUST BE ELIGIBLE FOR CSA RETIREE WELFARE FUND BENEFITS IN ORDER TO OBTAIN BENEFITS FROM RETIREE CHAPTER. BENEFITS ARE THE SAME AS THOSE PROVIDED MEMBERS. SURVIVORS WHO DO NOT HAVE A DRUG PLAN WILL BE PROVIDED WITH $1,500 IN DRUG REIMBURSEMENT AFTER A $1,500 DEDUCTIBLE