

V: Health, Dental, Vision, and Flex Spending Accounts

A. HEALTH INSURANCE

1. THE EMPIRE PLAN
2. HMO-BLUE
3. COST OF COVERAGE
4. HOW TO ENROLL
5. CHANGE OF STATUS
6. RETIREMENT COVERAGE

B. PRESCRIPTION DRUG PROGRAMS

C. DENTAL INSURANCE

1. UUP
2. M/C

D. VISION CARE

1. UUP
2. M/C

E. THE FLEX SPENDING ACCOUNT

1. DEPENDENT CARE ADVANTAGE ACCOUNT
2. HEALTH CARE SPENDING ACCOUNT

A. HEALTH INSURANCE

Eligibility

The following employees are eligible for health insurance under the New York State Health Insurance Plan (NYSHIP) coverage for themselves and/or their families (which includes qualified domestic partners).

- Full-time faculty and professional staff;
- Part-time (non-casual) faculty and professional staff employees who are employed at a salary rate which will yield total compensation of \$13,870 effective July 2, 2010.

Effective Date of Coverage

Providing you apply for coverage within the first 42 days of employment, coverage will become effective on the 43rd day of employment.

NYSHIP Options

The Empire Plan

[-Blue Cross](#)

[-United Health Care](#)

HMO - Blue

1. [THE EMPIRE PLAN](#)

The Empire Plan provides coverage for hospitalization through Blue Cross, and combined medical/surgical and major medical coverage through United HealthCare. You may incur additional costs by utilizing a non-participating provider or receiving unauthorized care. Please refer to the NYSHIP General Information Booklet for detailed plan information.

There is a \$70 co-payment for each emergency room visit. This co-payment is waived if you are subsequently admitted to the hospital. There is also a \$40 co-payment for each out-patient visit to a hospital, with the exception of visits for chemotherapy, radiation therapy, physical therapy or kidney dialysis. The plan features a network of participating providers (physicians, laboratories, chiropractors and other specialists and establishments). Services rendered by participating providers will generally be paid in full, with the exception of an \$20 payment for office visits, covered outpatient surgical procedures, radiology services, and diagnostic laboratory services. The insurance carrier pays the provider directly.

Claims for services by providers who do not participate in the Plan must be submitted using a claim form. Once a deductible is met, major medical will pay 80 percent of reasonable and customary charges. The 2014 annual deductible for employees who select non-participating providers is currently \$1,000 for the enrollee; \$1,000 for enrolled spouse/domestic partner; and \$1,000 for all dependent children combined. Thereafter, major medical will pay 80 percent of reasonable and customary charges (adjusted annually), and there is a deductible and coinsurance limits have been met, the plan pays 100 percent of reasonable and customary charges. Covered expenses for mental health and substance abuse, home care advocacy program services and managed physical medicine are excluded in determining the maximum out-of-pocket limit.

NOTE: Please refer to the Choices magazine and Empire Plan Certificate for additional information available at: <http://www.cs.ny.gov/ebd/welcome/login.cfm>.

2. HMO-BLUE (<https://www.excellusbcs.com/>) or HMO-MVP

HMO Blue provides a wide range of health services including hospital benefits, medical and surgical care and preventative care. These services are provided or arranged by a primary care physician whom you select from the HMO participating providers. HMO's have no annual deductible. Referral forms to see network specialists are usually required.

3. COST OF COVERAGE

The State pays 90 percent of the cost of the premium for individual coverage and 75 percent of the cost of dependent coverage provided under the Empire Plan. The State pays 90 percent of the individual coverage and 75 percent of the cost of dependent coverage towards the Hospital/Medical/Mental Health and Substance Abuse components for each HMO, however, not to exceed 100 percent of its dollar contribution for those components under the Empire Plan. Your portion of the premium will be automatically deducted from your bi-weekly salary. The 2014 bi-weekly costs for participation in these plans are as follows:

Plan	Individual Coverage	Family Coverage
Empire Plan	\$53.78	\$191.35
HMO Blue	\$169.18	\$497.48
HMO MVP	\$120.99	\$344.53

You may elect to pay your share of health insurance premiums on a pre-tax basis. These costs are subject to change.

If an employee takes leave without pay or is otherwise temporarily removed from the payroll, he or she may pick up the full cost of the health insurance program and thereby continue coverage while off the payroll. Should such leave without pay occur as part of an authorized leave under FMLA, he or she may be entitled to continue coverage by paying the employee share. Arrangements for continued coverage must be made in advance through the Office of Human Resources.

If an employee covered by the Empire Plan is totally disabled, and on authorized leave without pay or unpaid Family and Medical Leave, the requirement that he or she pay a premium may be waived for a period of up to one year. Additional information is available from the Office of Human Resources.

4. HOW TO ENROLL

Complete the appropriate sections of the New York State Health Insurance Transaction form and submit to Office of Human Resources. If you elect an HMO option, you will also need to complete a separate HMO enrollment form.

Proof of eligibility must be provided in order for you and your eligible dependent to enroll in NYSHIP. For enrollee, spouse and child(ren), documentation of the following is required:

- Date of Birth
- Social Security Number
- Date of Marriage/Date of Divorce

The following documentation may also be required:

- Domestic Partner – Completed PS-425 and proof of date of birth
- Adopted child(ren) – proof of adoption
- Stepchild(ren) who do not reside with you – proof of substantial support or legal requirement to pay
- Other Child(ren) – Statement of Dependence PS-457

5. CHANGE OF STATUS

If an employee wishes to change health insurance coverage as a result of a birth, death, or other change in family status, he or she must submit an application or change to the Office of Human Resources.

CHANGE OF PLAN OPTION

There is an annual transfer period (usually in November/December) during which you can, should you wish, change your option.

6. RETIREMENT COVERAGE

If you meet specific criteria, you will be eligible to continue individual coverage and that of enrolled dependents during retirement. In general, you must complete at least ten (10) years of eligible service; be at least 55 years of age and have coverage at the time you retire. You may, at your discretion, suspend health insurance coverage after you retire.

B. PRESCRIPTION DRUG PROGRAMS

EMPIRE PLAN

Each of the health insurance options provides prescription drug coverage for covered employees and dependents.

If you elect the Empire Plan, there is a \$5 co-payment for all new generic prescriptions and refills purchased at participating pharmacies. The co-payment for preferred brand name drugs is \$25. The co-payment for non-preferred brand name is \$45. Coverage is through Medco. Show your New York Employee Benefit Card at the time of purchase.

There is a mandatory generic substitution requirement. If you purchase a brand name drug with a generic equivalent, you will pay the co-payment plus the difference in cost between the brand name and generic drugs.

You can receive up to a 90 day of your covered prescriptions by mail order from Medco, telephone number 1-877-769-7477, or at a participating pharmacy.

HMOS

Under each of the Health Maintenance Organization options, prescriptions must be filled at a participating pharmacy or via mail order (if available). The co-payments for each of the Health Maintenance Organizations options are as follows:

HMO Generic Preferred Non-preferred

HMO \$10 \$30 \$50

ADDITIONAL INFORMATION

Specific information on health plan benefits is provided in these booklets available from the Office of Human Resources.

C. DENTAL INSURANCE

1. UUP

The United University Professions (UUP) Benefit Trust Fund provides employees in the Professional Services Negotiating Unit who are eligible for enrollment in the New York State Health Insurance Program with dental benefits (Delta, <http://www.deltadentalins.com/uup/>] Group #165). Note: The union benefit fund exists solely to provide benefit coverage to UUP-represented employees. The cost is funded by payments UUP negotiates for, and receives from, the state. Union dues and agency shop fees do not pay for these benefits.

New employees become eligible for coverage as soon as they complete 42 days of continuous service. Eligible employees who transfer directly from another state agency will become eligible for benefits the day after their previous coverage ends.

Eligible employees are free to select a dentist of their choice. The participating dentists have entered into an agreement with Delta to abide by established policies regarding services, charged fees and other matters. A listing of participating dentists can be obtained from directly listings available from the UUP Benefit Trust Fund or by calling Delta.

For eligible members, most diagnostic, preventative and restorative services, coverage is 80 percent of the local Usual and Customary and Reasonable (UCR) diagnostic fees. For basic restorative care, reimbursement is 60%. For major restorative care and orthodontics, reimbursement is 50%. There is a \$2,500 calendar year maximum for Orthodontia services. For major services and orthodontics, coverage is determined according to a fee schedule. Orthodontic benefits are also available.

When using a participating dentist, the dentist will receive payment and the member will receive an explanation of benefits. The dentist will bill the patient for the remaining balance. When using a non-participating dentist, the member will receive the payment (calculated on a UCR basis) and be responsible for payment of the non-participating dentist's total fee.

SPECIAL NOTES:

- For charges in excess of \$500, a pre-determination is required.
- Claims submitted six months or more beyond the date of service would not be eligible for payment.
- Dental benefits may be based on the least costly treatment that conforms to generally accepted dental practice.
- Orthodontic benefits may be pro-rated for treatment begun before the patient is covered.

Claim forms are available at the Office of Human Resources, or may be obtained directly from the [UUP Benefits Trust Fund](#).

2. M/C

New York State provides M/C employees with a group dental insurance plan, administered by Group Health Incorporated (GHI). The entire cost of the coverage is paid by the State for eligible employees and dependents. The plan covers a broad range of dental work. If an employee chooses to use a participating dentist, all covered fees are paid by the plan. If the employee chooses to use a non-participating dentist, reimbursement is made in accordance with a fee schedule based on a Statewide average. The employee is responsible for any difference between the dentists' fees and the plan's payment schedule. Coverage under this plan is automatic and is subject to certain deductibles. The eligibility requirements for an employee, dependents, and domestic partners are the same as that for the health insurance program.

Coverage under this Plan is effective on the first day of the month after an employee has completed six full calendar months of continuous employment. The employee may have satisfied the six month period of employment in a non-eligible position. In this event, the effective date is the first day of the month following the date of transfer to an eligible position.

There is an annual deductible, for all services except Preventative Care, Diagnostic Care and Orthodontics. The deductible is \$25.00 per person per calendar year. The total family deductible will not exceed \$75.00 per year for all covered family members. The amount of the deductible is based on GHI's schedule, not on the amount charged by the dentist.

D. VISION CARE

1. UUP (www.eyemedvisioncare.com)

The United University Professions (UUP) Benefit Trust Fund provides employees in the Professional Services Negotiating Unit who are eligible for enrollment in the New York State Health Insurance Program with vision benefits (Davis Vision).

Note: The union benefit fund exists solely to provide benefit coverage to UUP-represented employees. The cost is funded by payments UUP negotiates for, and received from, the state. Union dues and agency shop fees do not pay for these benefits.

New employees become eligible for coverage as soon as they complete 42 days of continuous service. Eligible employees, who transfer directly from another state agency, will become eligible for benefits the day after their previous coverage ends.

Eligible members and their dependents receive benefits from Davis Vision once every 12 months. The plan allows payment for one pair of eyeglasses without a co-payment (from a select frame assortment) or plan-covered contact lenses with a co-payment. Davis Vision will send eligible employees a listing of participating providers. If a member chooses to use a non-participating provider, s/he will be eligible for reimbursement of \$10 for the exam and \$35 for glasses, frames or contact lenses. Additional benefits (such as scratch coating and upgraded frames) are available to members at a discounted cost.

2. M/C (www.eyemedvisioncare.com)

Eligible M/C employees, their dependents, and their domestic partners are eligible for vision care coverage under the M/C Vision Care Plan (EyeMed). If an employee chooses to use a participating provider for vision care needs for the entire cost of an examination and eye glasses or standard allowance for contact lenses. If the employee chooses a non-participating provider, payment will be made directly to the employee according to a fixed schedule. Plan benefits are available to each covered person once in each 24 month period. All full-time and half-time salaried M/C employees are eligible for coverage. Dependent and domestic partner eligibility is identical to that of the State Health Insurance Program.

An eligible M/C employee must enroll in the M/C VISION CARE PLAN in order to take advantage of the services provided under the plan. Newly eligible employees will automatically receive an enrollment form and plan information at their residence after they have been on the payroll for 56 days.

E. THE FLEX SPENDING ACCOUNT (www.flexspend.ny.gov)

There are two parts to the Flex Spending Account – the Dependent Care Advantage Account (DCA Account) and the new Health Care Spending Account (HCS Account). Both are a type of Flexible Spending Account (FSA). FSAs give you a way to pay for your dependent care or health care expenses with pre-tax dollars. FSAs are voluntary - you decide how much to have taken out of your paycheck and put into your DCA Account and/or HCS Account.

1. Dependent Care Advantage Account

Generally, a qualifying dependent is a person who:

- qualifies as a dependent on your federal tax return, and
- in the case of a family member, is a child under age 13, or an individual physically or mentally incapable of self-care.

Married persons filing a joint income tax return, and single parents, may contribute up to \$5000 per calendar year to a dependent care account, while married persons filing a separate return may contribute up to \$2500. The Internal Revenue Service requires you to provide the name, address and taxpayer identification number (or Social Security number) of your dependent care provider. Eligible expenses are those for the care of a qualifying dependent either inside or outside the home (but not residential expenses, e.g., nursing home) to enable you (or if married, you and your spouse) to work. If care is provided outside the home, your dependents must spend at least eight hours a day in your household.

Your dependent care account can be used to pay for such expenses as:

- nursery schools and day care centers
- centers that provide day care for qualifying adult dependents (not residential care)
- care provided either in or outside the home by individuals other than your dependents or your children under age 19
- day camps
- Before/after school programs

Because of the tax advantages of a flexible spending account, the Internal Revenue Service has imposed strict limitations on the use of before-tax contributions. One IRS rule, commonly referred to as the "use it or lose it" rule, requires a forfeiture of any amounts credited to your account which are not used to pay eligible expenses during

the plan year. If you wish to participate in this program, you should carefully estimate the costs of your dependent care for the year before deciding on the amount you wish to contribute per pay period, since your annual election to contribute to the plan is irrevocable (i.e., cannot be changed) except for a change in your family status.

Change in Family Status: The IRS regulations allow participants to modify contribution elections to their dependent care account if the family situation changes. A change in family situation includes (1) marriage, (2) divorce or separation, (3) birth or adoption of a child, (4) change in you or your spouse's employment status or situation, or (5) death of a dependent.

If you presently qualify for participation in the Dependent Care Advantage Account, you must enroll in the program within 60 days of your Advantage Account, you must enroll in the program within 60 days of your State appointment. If you do not enroll within this window period, you will not be able to enroll at a later date, unless you enroll during an annual open enrollment period or you have a qualified change in family status.

The deadline for filing a claim for reimbursement from your Dependent Care Account is March 31st following the year in which the services were rendered.

If you are interested in participating in this Dependent Care Advantage Account, you may contact the Office of Human Resources for an enrollment packet and application (phone 267-2096). You may also contact the DCAA Hotline at 800-358-7202.

2. Health Care Spending Account

The Health Care Spending Account (HCS Account) allows State employees to pay for health-related expenses with tax-free dollars. This includes medical, hospital, laboratory, prescription drug, dental, vision, hearing expenses and OTC drug coverage that are not reimbursed by your insurance. To be reimbursed through the HCS Account, expenses must be for health care received primarily for the prevention or treatment of a physical or mental defect or illness. Out-of-pocket expenses are generally eligible if they are not reimbursed by insurance. Whether these expenses are incurred by you or your eligible dependents, they must be incurred during the Plan Year. An expense is incurred when you or one of your dependents receives the health care service, and not when you are billed, charged for, or pay for the service. To be eligible for reimbursement, a health care expense must be:

- for you or an eligible dependent;
- permitted under the Internal Revenue Code;
- medically necessary; and not reimbursed by your health insurance.

You may claim eligible expenses under the HCS Account program for the following individuals:

- yourself
- your spouse and
- your eligible tax dependents

Before participating in the HCS Account program, you should carefully consider what your eligible expenses might be. Reviewing your expenses from previous years can help. Once you have estimated the amount of your expenses, you may then determine how much to contribute to your HCS Account. Under federal law, any money that you put into your HCS Account must be used for expenses incurred during the Plan Year in which it was contributed. For the 2009 plan year, the maximum annual contribution allowed by the program is \$4,000 and the minimum annual contribution is \$100.

No reimbursement can be made prior to the service actually being provided. However, you are entitled to receive full reimbursement for eligible expenses, up to the amount of your annual election, once proper documentation has been submitted, even before you have fully contributed to your HCS Account.

You will forfeit any money that remains in your account. You will have until March 31 of the following year to send in claims for expenses you incurred the previous year. Any forfeitures will be used by the State to offset the costs of administering the program. This is the "use it or lose it" feature of the plan, as required by the Internal Revenue Code.

New employees will become eligible to participate after they have completed sixty (60) consecutive calendar days of State service and if they meet the eligibility criteria. To participate, new employees must submit an enrollment form within thirty (30) days of their employment start date. Your plan year contribution amount will be prorated over the remaining pay periods. You will also have an opportunity to enroll in the HCS Account each fall during an open enrollment period.

For more information, please contact [Melissa Proulx](#), Director of Human Resources