Office of Labor Relations
EMPLOYEE BENEFITS PROGRAM

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COBRA Information Concerning Continuing Health Coverage in the State of New York

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

This notice is intended to inform you of your rights and obligations under the continuation coverage provisions of this law.

COBRA Eligibility for:

Employees Not Eligible for Medicare

Employees whose health and/or welfare fund coverages are terminated due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct) are eligible for COBRA. Termination of employment includes unpaid leaves of absence of any kind. More information concerning situations involving termination due to gross misconduct is available from your agency benefits representative.

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

Spouse/Domestic Partner Not Eligible for Medicare

A spouse/Domestic Partner who loses coverage for any of the following reasons is eligible for COBRA continuation under any of the available NYC health benefits plans and the applicable welfare funds if your health insurance or welfare fund benefits are reduced or terminated for any of the following reasons:

1) death of the City employee or retiree; 2) termination of the employee's City employment (for reasons other than gross misconduct); 3) loss of health coverage due to a reduction in the employee's hours of employment; 4) divorce from the City employee or retiree; 5) termination of domestic partnership with the City employee or retiree; or 6) retirement of the employee (refer to the Health Benefits Program Summary Plan Description (SPD) for retiree eligibility).

Dependent Children Not Eligible for Medicare

Dependent children who lose coverage for any of the following reasons are eligible for COBRA under any of the available NYC health benefits plans and the applicable welfare fund if coverage is reduced or terminated for any of the following reasons:

1) death of a covered parent (the City employee or retiree); 2) the termination of a covered parent's employment (for reasons other than gross misconduct); 3) loss of health coverage due to the covered parent's reduction in hours of employment; 4) the dependent ceases to be a "dependent child" under the terms of the Health Benefits Program; or 5) retirement of the covered parent (refer to the Health Benefits Program SPD for retiree eligibility).

Disabled Individuals

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

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

Medicare-Eligible Individuals

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

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

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

CITY OF NEW YORK EMPLOYEE BENEFITS PROGRAM
CONTINUATION OF COVERAGE APPLICATION

Date of Qualifying Event
/ /

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

☐ Termination of Employment/Member ☐ Reduction of Work Schedule ☐ Divorce or Legal Separation ☐ Termination of Domestic Partnership
☐ Death of Employee/Retiree ☐ Loss of Eligibility as a Dependent Child

Present or former Contract Holder's Name: _____ Present or Former Health Plan: _____ Social Secruity Number: _____

Relationship to Present or Former Contract Holder }
☐ Self
☐ Spouse (former or current)
☐ Domestic Partner
☐ Son
☐ Daughter

Present or Former City Employee's Welfare Fund: _____

APPLICANT INFORMATION (PLEASE PRINT)

Last Name:	First Name:	M.I.:	Social Security Number:	Home Telephone #: ( )
Mailing Address:		Apt.:	Date of Birth:	Sex: ☐ Male ☐ Female
City:		State:		Zip Code:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Domestic Partner ☐ Legally Separated ☐ Divorced
Date of Marital Status Event: / /

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

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

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

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

☐ Aetna EPO ☐ GHI-CBP/EBCBS ☐ DC 37 Med-Team ☐ MetroPlus ☐ Anthem EPO - Nationwide
☐ Anthem Blue Access EPO ☐ Vytra Health Plan ☐ GHI HMO ☐ HIP Prime HMO ☐ HIP Prime POS
☐ OTHER _____

Optional Benefits (Please check one): ☐ Yes ☐ No

WELFARE FUND - COBRA

Contact your your union or welfare fund directly for the necessary forms, available options and costs. You will pay the union welfare fund directly for the cost of these benefits.

AUTHORIZATION

I certify that the above information is correct. I fully understand that I am responsible for the full cost of my continuance of coverage and will be subject to the terms and condictions of the group contract.

_____ / /
Applicant's Signature Date

I choose to waive my rights to extend my current health coverage under COBRA. I wish to convert to a direct payment policy. Please send me a conversion contract.

_____ / /
Applicant's Signature Date

THIS NOTICE MUST BE MAILED DIRECTLY TO YOUR HEALTH PLAN
FOR COBRA CONTINUATION COVERAGE OR FOR DIRECT PAYMENT CONVERSION
(See Plan Description for address)

COBRA Premiums

If you enroll in COBRA, you are responsible for paying the full premium for your plan and coverage. The premium levels indicated on the back of this page reflect 102% of the current rate (since these rates are subject to change, you should check with the health plan to determine the premium at the time of your COBRA enrollment). Payments may be made monthly on the first of the month. There is usually a 30-day grace period.

The City will not "carve out" benefits provided through your Welfare Fund that are similar to those available in your plan's Optional Rider. If you decide to purchase the Optional Rider, you mustpay for the entire Optional Rider offered by your chosen plan. If you decide to purchase any of your Welfare Fund benefits, you should contact your Welfare Fund to determine what benefits are available, and the associated cost.

Health Plan Addresses

Payment should be mailed directly to the plan chosen for COBRA continuation coverage. Please see below for the health plan addresses:

Health Plan	Mailing Address	Email/Fax
Aetna	Aetna City of New York - Mail Code F314 PO Box 818013 Cleveland, OH, 44181 Attn: Jennifer Robertson	Fax: 1-860-907-3010 Email: mailto:conymailbox@aetna.com
Anthem EPO Anthem Blue Access Gated EPO	Anthem EPO Anthem Blue Access Gated EPO PO Box 645438 Cincinnati, OH 45264-5438 Attn: Lashern Pendergast	Email: mailto:lashern.pendergrast@anthem.com
DC 37 Med-Team	DC 37 Med-Team 125 Barclay Street, New York, New York 10007 Attn: Accounting Department: Magaly Mendez-Bravo	
EmblemHealth: • GHI-CBP/Anthem BCBS • GHI HMO • GHI Health • HIP Prime HMO • HIP Prime POS • VYTRA	EmblemHealth 55 Water Street New York, NY 10041 Attn: Emblem Health Enrollments	Email: NYCmembership@emblemhealth.com or NYCleads@embemhealth.com
MetroPlusHealth	MetroPlusHealth 50 Water Street, 7th Fl. New York, NY 10004 Attn: COBRA Enrollments	Fax: (212) 908-8429 Email: mailto:citygold@metroplus.org

*The GHI CBP/EBCBS is offered as package under COBRA. The premium should be sent to the EmblemHealth address indicated above.

Welfare Fund Benefits Contact your welfare fund directly for COBRA information and rates. If you do not wish to continue coverage of welfare fund benefits under COBRA, conversion to private coverage may be available for medical and life insurance benefits within45 days of termination of coverage.

NON-MEDICARE Monthly COBRA Rates for Effective July 2025

PLAN	Coverage	COBRA RATE
Aetna EPO	INDIVIDUAL BASIC	$2,097.65
	FAMILY BASIC	$6,056.13
	INDIVIDUAL with RIDER	$5,265.48
	FAMILY with RIDER	$15,242.78
Anthem EPO	INDIVIDUAL BASIC	$2,564.09
	FAMILY BASIC	$6,411.11
	INDIVIDUAL with RIDER	$3,218.42
	FAMILY with RIDER	$8,015.22
Anthem Blue Access Gated EPO	INDIVIDUAL BASIC	$1,675.33
	FAMILY BASIC	$4,348.67
	INDIVIDUAL with RIDER	$2,329.66
	FAMILY with RIDER	$5,952.78
DC-37 Medteam (no rider available)	INDIVIDUAL BASIC	$1,210.32
	FAMILY BASIC	$2,968.69
GHI-CBP/ABCBS	INDIVIDUAL BASIC	$1,172.91
	FAMILY BASIC	$3,080.22
	INDIVIDUAL with RIDER	$1,326.29
	FAMILY with RIDER	$3,365.73
GHI HMO	INDIVIDUAL BASIC	$1,614.53
	FAMILY BASIC	$4,111.75
	INDIVIDUAL with RIDER	$2,244.64
	FAMILY with RIDER	$5,718.68
HIP HMO Gold Preferred Plan (Grandfathered)	INDIVIDUAL BASIC	$1,210.32
	FAMILY BASIC	$2,968.69
	INDIVIDUAL with RIDER	$1,680.38
	FAMILY with RIDER	$4,120.31
HIP HMO Gold Preferred Plan (Standard)	INDIVIDUAL BASIC	$1,210.32
	FAMILY BASIC	$2,968.69
	INDIVIDUAL with RIDER	$1,375.39
	FAMILY with RIDER	$3,279.05
HIP Prime POS	INDIVIDUAL BASIC	$2,707.57
	FAMILY BASIC	$6,636.66
	INDIVIDUAL with RIDER	$3,310.16
	FAMILY with RIDER	$8,113.22
Metroplus (Grandfathered)	INDIVIDUAL BASIC	$1,210.32
	FAMILY BASIC	$2,968.69
	INDIVIDUAL with RIDER	$1,494.87
	FAMILY with RIDER	$3,680.06
Metroplus (Standard)	INDIVIDUAL BASIC	$1,210.32
	FAMILY BASIC	$2,968.69
	INDIVIDUAL with RIDER	$1,344.46
	FAMILY with RIDER	$3,224.91
Vytra	INDIVIDUAL BASIC	$1,538.43
	FAMILY BASIC	$4,039.39
	INDIVIDUAL with RIDER	$2,075.70
	FAMILY with RIDER	$5,437.17

MEDICARE Plans Monthly COBRA Rates for Effective January 2025

PLAN	Coverage	COBRA RATE
GHI Senior Care	PER PERSON BASIC	$228.87
	PER PERSON with RIDER	$385.61
GHI HMO Medicare Senior Supplement	PER PERSON BASIC	$992.38
	PER PERSON with RIDER	$1,109.68
Anthem Medicare Related	ONE PERSON BASIC	$412.12
	ONE PERSON with RIDER	$673.58
DC-37 Medteam	PER PERSON BASIC	$228.87
	RIDER NOT AVAILABLE	
Aetna PPO/ESA (NY/NJ/PA)	PER PERSON BASIC	$99.44
	PER PERSON with RIDER	$266.34
Aetna PPO/ESA (All other areas)	PER PERSON BASIC	$119.44
	PER PERSON with RIDER	$209.48
HIP VIP	PER PERSON BASIC	$198.50
	PER PERSON with RIDER	$388.50

Rates are Subject to Change

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

Return the completed COBRA form to your chosen plan. Addresses are listed on the front of this pamphlet. Wait for notification from the plan before mailing in your first payment. Checks and/or money orders must be made payable to the health plan and mailed DIRECTLY to the plan.

Enrollees of all plans not listed must contact the plan DIRECTLY for enrollment options.

Notice

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

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

1. The premium for continuation coverage is not paid in a timely fashion;

2. The continuation enrollee becomes covered as an employee or dependent under another group health or welfare plan (under this occurrence the spouse and dependents may continue their COBRA coverage for the remaining months of eligibility).

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

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