December 2, 2019

Dear SEHP enrollee:

Effective January 1, 2020, the employee share of the biweekly premium for enrollees in the Student Employee Health Plan (SEHP) under the New York State Health Insurance Program (NYSHIP) will be:

- Individual coverage: $16.86
- Family coverage: $117.47

The new rate will be deducted automatically from employees' biweekly paychecks beginning with the paycheck dated:

- December 24, 2019 for Administration Lag-Payroll employees, and
- January 2, 2020 for Institution Lag-Payroll employees.

If you have any questions about enrollment, eligibility or the cost of your health insurance, please contact the Health Benefits Administrator (HBA) in the Human Resources (Personnel) office on your campus.

The Summary of Benefits and Coverage (SBC) is a standardized comparison document required by the Patient Protection and Affordable Care Act. To view a copy of the SBC for SEHP, visit www.cs.ny.gov/sbc. If you do not have internet access, call 1-877-769-7447 to request a copy.

Note: If your employment with SUNY or CUNY in a benefits-eligible position is ending, contact the HBA on your campus to update your records. Be sure to ask about the date your coverage will end; it may be different from the date printed on your ID card. When your coverage has ended, please destroy your health insurance and dental plan ID cards. Claims you incur after your coverage ends will not be paid, unless you enroll for COBRA continuation coverage.

COBRA enrollees: Your monthly bills will reflect your new rate, beginning with the bill you receive in December 2019. If you have questions about the cost of your COBRA continuation coverage, or wish to end your COBRA continuation coverage, contact the Employee Benefits Division at 518-457-5754 or 1-800-833-4344.

Sincerely,

[Signature]

James DeWan
Director
Employee Benefits Division

2020 SEHP Rate Letter/SEHP NY1291
<table>
<thead>
<tr>
<th>PLAN</th>
<th>The New York State Health Insurance Plan (NYSHP) Student Employee Health Plan (SEHP) is a health insurance program for SUNY graduate and teaching assistants and their families.</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERAGE</td>
<td>Hospital, medical, surgical, prescription drug, vision and dental benefits using network and non-network providers.</td>
</tr>
<tr>
<td>ELIGIBILITY</td>
<td>Graduate and Teaching Assistants represented by GSEU who are active on the State payroll and work at least ½ an assistantship at a stipend that would yield total compensation of at least $ 4,293 on an annual basis.</td>
</tr>
</tbody>
</table>
| COST             | Biweekly premium rates for Spring/Fall 2020 will be:  
$ 16.86 Individual coverage  
$ 117.47 Family coverage |
| HOW TO ENROLL    | To enroll you should complete the enclosed PS-404G form and return it to the Human Resources office - Monday through Friday 8:30 am to 4:00 pm. **Proof of birth dates, social security numbers and marriage dates will be required for any dependents**. |
| COVERAGE EFFECTIVE DATE | If you enroll within 45 days of first becoming eligible your effective date of coverage will be the day we receive your enrollment form. If you request coverage after the 45 day open period, you may be required to serve a 30 day waiting period which begins the day we receive your form. |
| DEPENDENTS       | Legal spouse, domestic partner and children up to age 26. Includes natural children, dependent stepchildren, legally adopted children including those still within their waiting period for finalization. **Proof of birth dates, social security numbers and marriage dates will be required**. |
| INTERNATIONAL STUDENTS | F1 and J1 Visa Holders: Required to enroll in this plan. Must also purchase medical evacuation and repatriation coverage as a rider through the SUNY International Health Insurance Program. Contact ISSS Office or call Ext. 7-2510. |
| CHANGE OF COVERAGE REQUESTS | If you to elect to have your health insurance premiums deducted pre-tax, cancellation of coverage or change from family to individual coverage requires a qualifying event (job change, family change, new insurance eligibility, dependents returning to home country, etc.) and completion of form PS4040G to Human Resources with supporting documentation within 30 days of the qualifying event. |

**For more complete information regarding this plan please read in full the enclosed NYSHP – SEHP Benefit Summary brochure or go to [https://www.cs.ny.gov/employee-benefits/login/](https://www.cs.ny.gov/employee-benefits/login/). Select I am a Graduate Student enrolled in the Student Employee Health Plan**
Eligibility, Enrollment, and Cost for SEHP: Graduate Student Employees Union (GSEU)

Who is Eligible?
This section explains eligibility requirements for the NYSHIP SEHP coverage for you (the enrollee) and your dependents. You must be represented by the Graduate Student Employee Union (GSEU) and enrolled for NYSHIP SEHP coverage to be eligible for benefits.

You, the enrollee
1. Graduate student employees eligible for an employer contribution Under the NYSHIP SEHP are those who work at least one-half an assistantship and are employed at a stipend that would yield a total compensation of $4,293 or more for the contract year July 1 through June 30.

2. Employees who work at least one-half an assistantship but are hired mid-year will be eligible if they earn a stipend that would yield a total compensation equal to $4,293 or more when annualized from the July 1 through June 30 contract year.

3. A graduate student employee (and his/her dependents currently enrolled in NYSHIP’s Empire Plan or a NYSHIP HMO as an employee of New York State, a Participating Employer or a Participating Agency) is also eligible for coverage under the NYSHIP SEHP.

SUNY graduate student employee Visa holders
SUNY J1 and F1 Visa holders who meet the eligibility requirements for an employer contribution must enroll in the NYSHIP SEHP. The State University may waive this requirement to enroll if the F1 Visa holder can show proof of other coverage that, in the State University’s judgment, meets or exceeds the coverage provided by the NYSHIP SEHP.

Your dependents
The following dependents are eligible for coverage:

Your spouse
Your spouse, including a legally separated spouse, is eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage. However, an ex-spouse may be eligible to purchase a contract under COBRA if a timely application is made. You may also cover your same sex spouse, if the marriage is legal in the jurisdiction where it was performed.

Or your domestic partner
You may cover your same or opposite sex domestic partner as your dependent. A domestic partnership, for eligibility under the Plan, is one in which you and your partner are 18 years of age or older, unmarried and not related in a way that would bar marriage. You must be living together, involved in a lifetime relationship and financially interdependent. At the time of application, you must have been in the partnership for six months. Agency Health Benefits Administrators have complete information on eligibility, enrollment procedures and coverage dates.

Your child up to age 26
Your dependent children are eligible until they reach age 26. This includes your natural children, legally adopted children including children in waiting period prior to finalization of adoption, and your dependent stepchildren. Other children who reside permanently with you in your household, who are chiefly dependent on you for support (50 percent or more) and for whom you have assumed legal responsibility in place of the parent are also eligible.

- Disabled child age 19 or over
Your unmarried dependent children age 19 or over who are incapable of supporting themselves because of a mental or physical disability are eligible if the disability began before age 19. You must apply no more than 60 days after the child’s 19th birthday. You must provide medical documentation.

Questions?
If you have any questions concerning eligibility, please contact the agency Health Benefits Administrator on your campus, usually in the Human Resources (Personnel) office.

Enrollment and Effective Dates of Coverage
How to enroll
Eligible student employees may enroll as follows:
1. Within 45 days of first becoming eligible for coverage
2. During an annual open enrollment period, which is set by SUNY each year, usually from mid-August through late September?
3. Upon involuntary loss of other coverage
4. At any time, with a 30-day waiting period before coverage begins.

For domestic students (U.S. citizens and permanent residents), enrollment is optional except at campuses where health insurance coverage is mandated by the campus (e.g. University at Buffalo). See below for further information on mandatory enrollment.

Your agency Health Benefits Administrator will give you benefit plan information. Your identification card(s) will be mailed to you after you have enrolled.

A student employee who does not enroll his/her dependents at the time of initial enrollment may do so within 30 days of one of the following "Qualifying Events":

- Marriage
- Birth of a baby
- Employee becoming a child’s legal guardian, step-parent, or Adoptive parent
- Arrival of an eligible dependent in the United States
- Completion of the six-month waiting period for attainment of domestic partnership status
- Involuntary loss of other coverage

You are responsible for notifying your agency Health Benefits Administrator when you or your dependents are no longer eligible for coverage.

Mandatory enrollment of U.S. citizens and permanent residents at certain campuses
Domestic students at campuses where enrollment for health insurance coverage is mandated by the campus must enroll in the SEHP during the open enrollment or within 45 days of first becoming eligible, if they meet the eligibility requirements for an employer contribution and are not otherwise eligible to have the coverage requirement waived. Failure either to obtain a health insurance waiver or to enroll in the SEHP in a timely manner may result in the employee’s being automatically enrolled in the mandatory student health insurance program provided by the campus. The cost of the coverage provided by the campus would be paid entirely by the student.

No coverage during waiting period
Expenses incurred or services rendered during a waiting period will not be covered. Be sure to keep any other insurance you may have in effect, if possible, to cover expenses until your NYSHIP SEHP coverage becomes effective.
EFFECTIVE DATES FOR NEW ENROLLMENTS

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>New benefits-eligible appointment - application received within 45 days of appointment</td>
<td>Date of enrollment form is received in the SUNY Human Resources office, or the effective date of the appointment, whichever is later.</td>
</tr>
</tbody>
</table>

Exceptions:
- Employees on F1 Visas must have coverage as of their date of appointment.
- Domestic students at campuses where health insurance enrollment is mandated by the campus must have coverage as of their date of appointment.

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Open Enrollment Period (45-day period Determined by SUNY)</td>
<td>Date the enrollment form is receive in the SUNY Human Resources office, if received within the 45-day period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 days of involuntary loss of other coverage</td>
<td>Date the enrollment form is received in the SUNY Human Resources office.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Others</td>
<td>30 days after enrollment form is received in the SUNY Human Resources office</td>
</tr>
</tbody>
</table>

EFFECTIVE DATES FOR ADDITION OF DEPENDENTS

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 days of Qualifying Event</td>
<td>Date of the event</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 days of involuntary loss of other coverage</td>
<td>Date the enrollment form is received in the SUNY Human Resources office</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Others</td>
<td>30 days after the enrollment form is received in the SUNY Human Resources office</td>
</tr>
</tbody>
</table>

Cost
The State will contribute 90 percent of the cost of individual coverage and 75 percent of the additional cost for dependant coverage. You pay your share of the premium through biweekly paycheck deductions.

Benefits after termination of coverage
If you are totally disabled (because of sickness or injury you cannot do your job or your dependent cannot do his or her usual duties) on the date coverage ends on your account, your health insurance plan will pay benefits for covered medical expenses for that total disability, on the same basis as if coverage had continued without change, until the day you are no longer totally disabled or 90 days after the date your coverage ended, whichever is earlier.

Appeals
If a claim for benefits payment or request for precertification is denied in whole or in part, you have the right to begin an appeal process with the carrier. You must write to the carrier within 60 days after the claim payment date or the date of the notification of denial of benefits. After you have followed the carrier’s internal appeals process, under certain circumstances, you have the right to an External Appeal of a denial of coverage made on the basis that the service is not medically necessary or is an experimental or investigational treatment. You or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals. You must file your request with the Insurance Department (1-800-400-8882) within 45 days of either the date upon which you receive written notification from a carrier that it has upheld a denial of coverage or the date upon which you receive a written waiver of an internal appeal.

When coverage ends
Your coverage in NYSHIP SEHP will end 28 days after the last day of the last payroll period worked, even if your identification card has a different termination date. Do not use your card after coverage ends. It is insurance fraud for an enrollee or dependent to use the card to obtain services after eligibility for coverage ends.

COBRA: Continuation of Coverage
If you wish to continue NYSHIP SEHP benefits after your employment-based eligibility ends, you and your covered dependents have the right to elect COBRA within 60 days of your last day of coverage. Employees receive a COBRA application automatically when employment ends. Dependents may enroll in COBRA by writing to the Employee Benefits Division.

Conversion Contracts
If your employment with SUNY in a benefits-eligible position ends, or your dependent loses eligibility, you/your dependent will be entitled to direct-pay conversion contracts after NYSHIP coverage ends or after COBRA coverage in NYSHIP is exhausted. You do not need to provide evidence of insurability. The benefit package and premium costs for direct-pay conversion contracts will differ from what you have had under NYSHIP. Contact Empire BlueCross BlueShield and UnitedHealthcare for information. You will have 90 days from the date NYSHIP coverage ends to apply for conversion coverage.
### Vaccines

- Human papillomavirus (HPV)
- Pneumococcal pneumonia
- Meningococcal meningitis
- Varicella (chickenpox)
- Rotavirus
- Measles, mumps, rubella (MMR)
- Inactivated poliovirus (IPV)
- Haemophilus influenzae type b (HiB)
- Tetanus, diphtheria, pertussis (TDap)
- Hepatitis B
- Hepatitis A

### Screenings

- Age-risk individuals
- Screening for hepatitis B virus infection
- Acoustic and ding use assessments
- In school-aged children and adolescents
- Children to prevent injury to popesco's
- Counseling and education by primary care
- Counseling and education at the age of 6 months of age as well as counseling
- Skin cancer counseling for children beginning
- Domestic violence
- Child abuse and counseling for interpersonal and
- Counseling for adolescents at high risk
- Schooling for sexual and gender identity
- Schooling for major depressive disorders
- Osteoporosis screening and counseling for children
- Setting up to 6 years
- Application of medical services
- Hearing screening
- Age 2
- Visual Acuity screening for children up through
- Thrombosis screening
- Lead exposure screening up to age 7
- Cholesterol and lipid screening for children
- Blood pressure screening
- Hemoglobin or hemoglobin and blood
- Developmental screening up to age 3
- Certain newborn screenings including, but not limited to:
  - Newborn hearing screening
  - Newborn eye screening

**Note:** Vaccines administered as part of a primary care visit are not authorized in New York State for persons under age 18, with the exception of the

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### Preventive Services

To learn more, go to www.nyship.org/preventive-care/preventive-care-chart
Vaccines • Medications

<table>
<thead>
<tr>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screenings • Tests • Counseling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
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<tr>
<td>Screenings • Tests • Counseling</td>
</tr>
</tbody>
</table>

**Note:** Specific vaccines administered at a particular pharmacy are covered.

Yearly Preventive Care Physical and Well-woman exams are covered, as well as the screenings, tests, counseling and vaccines recommended for adults.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>UCR (usual and customary rate)</th>
<th>Sample cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>$475.40</td>
<td>$695.00</td>
</tr>
<tr>
<td>Administration</td>
<td>$350.00</td>
<td>$350.00</td>
</tr>
<tr>
<td>Biopsy</td>
<td>$210.00</td>
<td>$210.00</td>
</tr>
<tr>
<td>Breast reconstruction</td>
<td>$350.00</td>
<td>$350.00</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$650.00</td>
<td>$650.00</td>
</tr>
<tr>
<td>Lamotomy</td>
<td>$1,000.00</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Pathology</td>
<td>$700.00</td>
<td>$700.00</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>$350.00</td>
<td>$350.00</td>
</tr>
<tr>
<td>Radiology</td>
<td>$500.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>Surgery</td>
<td>$2,000.00</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>$350.00</td>
<td>$350.00</td>
</tr>
</tbody>
</table>

The above table provides an example of typical costs for out-of-network services under the Student Employee Health Plan in Suffolk County. This information is intended to give you an idea of the range of costs you might encounter for certain procedures. Always consult your insurance provider for specific details about your coverage.
Out-of-Network Reimbursement Disclosures

The Emergency Medical Services and Surprise Bills law requires The Empire Plan to provide information regarding your out-of-network reimbursement, including details on referrals, costs, coverage and surprise bills.

Out-of-Network Referral Mandate

The law requires The Empire Plan to provide access to primary care and specialty providers if these services are not available within a 30-mile radius or 30-minute travel time from your home address. This requirement applies to Empire Plan primary enrollees residing in New York State and those states/regions where the Plan has a UnitedHealthcare PPO Options agreement in effect, including Connecticut, New Jersey, Pennsylvania, Maryland, North and South Carolina, Florida, Arizona, Washington DC, Virginia, West Virginia and the Chicago, Illinois area. If you require access to a certain provider, contact the appropriate Empire Plan administrator at 1-877-7-NYSHIP (1-877-769-7447).

Out-of-Network Referrals

In addition, if The Empire Plan network does not have a provider accessible to you who has the appropriate level of training and experience to treat a condition, you have the right to request an out-of-network referral to a qualified provider. You or your attending physician must first request approval from the appropriate Plan administrator to receive consideration for the service to be paid at an in-network level. The attending physician must recommend the provider with the qualifications to meet the health care needs of the patient. The attending physician must provide this written recommendation on behalf of the patient, not the provider for whom the out-of-network referral request is being made.

If the Plan approves the request, you must use this approved out-of-network provider and covered services will be paid at the in-network benefit level, with only the applicable network copayment owed. You are responsible for contacting the provider to arrange care. If the Plan denies the request, benefits for covered services received from a nonparticipating provider are available under out-of-network benefit provisions, subject to deductible and coinsurance. You also can request an external appeal through the NYS Department of Financial Services (DFS).

Appeal of Out-of-Network Referral Denials

If The Empire Plan denies an out-of-network referral request because there is a geographically accessible in-network provider with the appropriate training and experience to meet your health care needs, you or your representative may file an appeal for an external review if:

- The service, procedure or treatment is otherwise covered under the Plan and
- You have received a final adverse determination through the internal appeal process

Appeals forms are available on the DFS website at www.dfs.ny.gov/complaints/file_external_appeal or by contacting them at 1-800-342-3736.

Out-of-Network Coverage and Cost Information

To comply with the mandate to help enrollees make informed decisions, The Empire Plan has taken the following steps:

- The Empire Plan online directories include hospital affiliation information for participating providers (be sure to cross reference the Plan’s hospital directory information to verify that the facility is in-network) as well as languages spoken. The 2019 printed versions of The Empire Plan Participating Provider Directories for New York State also include this information.
- To help you understand how much the Plan would pay for certain out-of-network services, the law requires disclosure of out-of-network reimbursement examples. See the chart on the reverse side.
- Out-of-Network Medical Estimation Tool: You can estimate the anticipated out-of-pocket cost for out-of-network services by contacting your provider for the amount that they will charge, or by using the FAIR Health website at www.fairhealthconsumer.org to determine the usual and customary rate (UCR) for out-of-network services in your geographic area or ZIP code.

Surprise Bills

Another provision of the law protects patients from being responsible for paying the full charge for surprise bills and generally applies only to services provided within New York State. Patients receive in-network benefits for any bill deemed to be a surprise bill.

What is a surprise bill?

When you receive services from a nonparticipating doctor, the bill you receive for those services will be a surprise bill if:

- You received services at an in-network hospital or ambulatory surgical center and a participating doctor was not available
- A participating doctor sent a specimen taken in the office to a nonparticipating laboratory or pathologist without your consent
- A nonparticipating doctor provided services without your knowledge
- Unforeseen medical circumstances arose at the time the health care services were provided

What is NOT a surprise bill?

If you electively seek care from an out-of-network provider when an in-network provider is available, any bills you receive are not considered to be surprise bills.

If you have questions about whether a bill meets this definition, contact the DFS at 1-800-342-3736 or visit www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills.

For claims submission information, see the contact page of your 2020 At A Glance.
**PART A: General Information**

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name

2. Employer Identification Number (EIN)

5. Employer address

6. Employer phone number

7. City

8. State

9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)

12. Email address

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to:
  □ All employees. Eligible employees are:

□ Some employees. Eligible employees are:

• With respect to dependents:
  □ We do offer coverage. Eligible dependents are:

□ We do not offer coverage.

□ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

<table>
<thead>
<tr>
<th>13. <strong>Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ <strong>Yes</strong> (Continue)</td>
</tr>
<tr>
<td>☐ <strong>No</strong> (STOP and return this form to employee)</td>
</tr>
</tbody>
</table>

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ____________ (mm/dd/yyyy) (Continue)

14. **Does the employer offer a health plan that meets the minimum value standard***? |
| ☐ Yes (Go to question 15) |
| ☐ No (STOP and return form to employee) |

15. **For the lowest-cost plan that meets the minimum value standard*** offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay. If the employee received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.**

   | a. How much would the employee have to pay in premiums for this plan? $ |
   | ☐ Weekly  ☐ Every 2 weeks  ☐ Twice a month  ☐ Monthly  ☐ Quarterly  ☐ Yearly |

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. **What change will the employer make for the new plan year?**

   | ☐ Employer won't offer health coverage |
   | ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.) |

   | a. How much would the employee have to pay in premiums for this plan? $ |
   | ☐ Weekly  ☐ Every 2 weeks  ☐ Twice a month  ☐ Monthly  ☐ Quarterly  ☐ Yearly |

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*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).
DEPENDENT CARE ADVANTAGE ACCOUNT (DCAA)

What is The Dependent Care Advantage Account?

The Dependent Care Advantage Account (DCAA) is a negotiated employee benefit that helps state employee families pay for custodial child care, elder care, or disabled dependent care while they are at work.

Call the FSA Hotline at 1-800-358-7202 or www.flexspend.ny.gov. You will receive expert assistance with questions you may have about the program.

How does the Dependent Care Advantage Account work?

If you are paying a caregiver to care for your child, elderly parent, or disabled spouse in order to work, you can set aside up to $5,000 per year in pre-tax salary through payroll deduction to help pay for those expenses. After caregiving services are provided, simply submit a reimbursement request form for your eligible expense and you will be reimbursed from your DCAA.

Who is Eligible to Enroll?

Employees who work for Executive Branch state agencies, the State University of New York, the Legislature, and the Unified Court System are eligible to participate in the DCAA. Part-time employees are eligible as long as their biweekly paychecks can support their DCAA deductions.

Employer Contribution

DCAA employer contribution will be available for 2020 for unions that participate in the employer contribution. The GSEU 2020 plan year employer contribution rate is $600.

What expenses can I pay through my DCAA?

You can use your DCAA to pay for dependent care expenses that are necessary for you and your spouse (if you are married) to work or go to school. The expenses must be for the care of individuals who live in your household at least eight hours a day.

- Child care expenses (12 years old or younger)
- Elder care expenses
- Expenses for a spouse or other dependent of any age who is mentally or physically incapable of self-care.

Here is a list of some eligible expenses: Adult daycare, Au pair, Babysitter, Before/after school programs, childcare center, family daycare provider, home aide, nursery school, pre-school program, sports day camp.

How do I get the money from my account when I need it?

After you have received services and incurred eligible expenses, you can choose from several options to be reimbursed for your expenses. Just fill out a claim form and attach a copy of your receipts. You can submit your claims online through the FSA administrator’s website, or mail or fax your claims to the address or fax number on the form. Most claims that are submitted online or by fax or mail are processed within one to two business days after they are received, and payments are sent shortly thereafter. You can receive your payments faster by enrolling in the direct deposit option to have your reimbursements deposited directly to your savings or checking account.

What’s the catch? Use it or lose it!

If you overestimate your costs for the year and don’t submit request for reimbursement, you will lose any money remaining in your account at the end of the plan year. This is the IRS’s “use it or lost it” rule. The key is to estimate your expenses carefully. You will have an extra three months after the plan year ends to file your claims, but they must be for services that were received during the plan year.

How do I enroll?

First, estimate your expenses and decide how much of your salary you want to set aside in order to cover those expenses. You can enroll either online at www.flexspend.ny.gov or by calling the FSA Hotline at 1-800-358-7202. As a new employee, you are eligible to enroll or there is an open enrollment period held annually in the fall.
### Graduate Student Employees Represented by CSUF

#### Benefits At A Glance

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<th><strong>Cost</strong></th>
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<th><strong>Eligibility</strong></th>
<th><strong>Description</strong></th>
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**Part-time, Benefits-Eligible:**
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