PARA-P.A.Benefits FAQ

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NOTIFICATIONS

To Join/Pay Dues

https://www.paranynj.org/join-para-form/

Address Changes

How can I change my address?

Retirees and eligible surviving dependents are required to notify HR Service Delivery when a change of address occurs by completing the Retiree Change of Address Form which can be found on the PARA website. (See Below) You can email the completed form to hr_employeebenefits@panynj.gov or mail to HR service delivery, 150 Greenwich St., 16th floor, New York, NY 10007 or fax 212-435-2871. Retirees/surviving dependents can also send in an authorized letter that should include the following: old/new address information, email address, updated phone number, signature of the eligible requestor, date, retiree's ID # (if applicable) or the last 4 digits of the retiree's Social Security number.

In addition, members must contact New York State Local Retirement System (NYSLRS) separately to update their addresses. NYSLRS (pension) can be reached at 866-805-0990.

> https://paranynj.org/paranynj/assets/File/public/benefits/Retiree-Change-of-Address-Form.pdf

NYSLRS Change of Address

https://www.osc.state.ny.us/retirement/retirees/change-address?redirect=legacy

You can contact us (/contactus/) regarding your address change by email, letter, fax or telephone. If you're sending a letter or fax, be sure to include your old and new address, retirement or social security number, and signature in your correspondence. If you call us, we'll ask you questions confirming your identity before we change your address in our records. If you email us, we will call you and ask you questions confirming your identity before we change you address in our records. Please realize that we must have a signed letter from you if your new address includes a PO Box or a location outside of the United States.

Mailing Address:
New York State and Local Retirement System
Pensioner Services
6th Floor 100, State Street
Albany, NY 12244-0001

Phone Numbers: (Certain automated phone information available 24/7)
Long Distance with the 50 states, Puerto Rico and Virgin Islands, toll free: 1-866-805-0990
Locally within the Albany, NY area, call: 518-474-7736

General Fax Number: 518-402-4433

Please include your name, social security number and a phone number where we can reach you as well as the name or department that you are trying to reach with your fax.

DEATH NOTIFICATIONS

Reporting of Member's or Retiree's Death

Who does my family notify of my death?

P.A. Employee Benefits (health/dental) 212-435-2870
Please send an email to:
retirement@panynj.gov

Prudential Insurance Company of America (life-insurance) 800-778-3827

New York State and Local Retirement System (pension) 866-805-0990 NYSLRS
Notification of Death Form:
https://www.osc.state.ny.us/files/retirement/forms/pdf/rs6082.pdf

Railroad Retirement 877-772-5772

PATH Supplemental Pension (Korn Ferry) 212-984-9304 or 212-896-9923

Reporting of Member's or Retiree's Death to NYSLRS

When a NYSLRS member dies, whether before or after retirement, it's important that survivors report a member's or retiree's death to NYSLRS as soon as possible. Survivors can report a death by email, phone or mail. They will need to send NYSLRS an original certified copy of the member's death certificate regardless of how they notify NYSLRS.

Once NYSLRS receives the death certificate they will send beneficiaries or their certified representatives (guardians, powers of attorney, executors) information about death benefits and, if applicable, information about continuing monthly retirement benefits. They will also send them forms to complete. Beneficiaries should be aware that it could take **three months** from the date NYSLRS is notified of the death before any death benefit is paid or any monthly benefit payment begins.

If a member is retired when he or she dies, NYSLRS will stop payment of any outgoing pension benefits. Survivors should be aware that any uncashed pension checks in a deceased retiree's name must be returned to NYSLRS. NYSLRS will automatically reclaim any direct deposit payments that went out after a member's death.

Additional information on Getting Your Affairs in Order and Survivors Guide can be found at:

https://www.osc.state.ny.us/retirement/publications/getting-your-affairs-order-and-guide-survivors?redirect=legacy

REFERENCES IN THIS DOCUMENT ARE NOT INTENDED TO REPLACE THE DEFINITION IN ANY SUMMARY PLAN DESCRIPTION BOOKLET

BENEFITS ELIGIBILITY FOR HEALTH/DENTAL

Does my health coverage continue for my spouse after my death?
Yes, as long as he/she remains unmarried.

Can I add a new spouse to my benefits coverage as a retiree?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (PA 2298) and return it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.)

Can my dependents stay on my coverage after retirement?

Dependent children are dis-enrolled from benefits when they are no longer eligible (e.g., at the end of the calendar year in which the child turns 26). Spouse's coverage continues unless they lose eligibility due to divorce or you intend to drop them voluntarily.

Can my dependents stay on my coverage after age 26 and are disabled?

Prior to becoming incapacitated, the child must have been covered as an eligible dependent under the plan and meet the following conditions. (1) the child is mentally or physically incapacitated; (2) the child is not capable of self-support; and the child depends on you for support. This must be done before the child is dis-enrolled from the benefits because they are no longer eligible at the end of the calendar year in which the child turns 26.

Please contact the health insurance carrier (ex: UHC) for formalities regarding submitting the form attesting to the disability for review and approval by the insurance carrier.

Please explain "incapacitated coverage for handicapped children."

Prior to becoming incapacitated, the child must have been covered as an eligible dependent under the plan and meeting the following conditions: (1) the child is mentally or

physically incapacitated; (2) the child is not capable of self-support; the child depends on you for support.

Can I keep my ex-spouse on my coverage?

Generally, ex-spouses are not eligible for health insurance benefits through the Port Authority. However, if the employee is legally responsible for the support of such legally separated or divorced spouse and the legally separated or divorced spouse has not remarried, and the employee has not remarried, then an ex-spouse could be eligible.

As a surviving spouse/dependent do I keep my current benefits?

Yes, provided the surviving spouse does not remarry. It is the responsibility of the surviving spouse to notify Port Authority when they remarry. Failure to do so in a timely manner will constitute fraudulent behavior and as such surviving spouse will be responsible to pay for all claims back to the date of remarriage.

Port Authority Employee Personal Status Change, form PA 2298:

https://paranynj.org/paranynj/assets/File/public/benefits/PA2298.pdf

RETIREE HEALTHCARE

How can I view my retiree benefit elections?

Please register on the Insurance Provider's website (on the back of your card) where you will be able to review your benefits.

When does the $5 co-pay plan end?

The $5 co-pay plan ends when you retire after age 65 or have been receiving Social Security Disability Insurance (SSDI) for 24 months, and Medicare becomes your primary payer.

How do I find out which doctors are in the PPO plan and will accept a $5 co-pay?

You can obtain a network provider directory by contacting UHC at 1-877-259-1391 or by checking their website at https://www.myuhc.com.

Medicare

I am turning 65, soon to be Medicare-eligible. How will my health benefits change?

Most retirees enroll in Medicare when they reach age 65. You can expect to receive information from the Social Security Administration (SSA) at least 3 months prior to your 65th birthday. You are required to enroll in Medicare Part A and B. Port Authority will enroll you in the Port Authority's Medicare Part D Plan through Express-Scripts. Please provide you Medicare Care to HRSD via email hr_employeebenefits@panynj.gov. You should also expect to receive a letter from Express-Scripts requesting your Medicare Card if you have not already provided it to the Port Authority.

Medicare becomes your primary insurance and UHC becomes your secondary insurance on the 1st day of the month when you turn 65 (or if your birthday is on the 1st, Medicare is primary on the 1st of the prior month).

How much is my Medicare Part B premium?

The standard Part B premium amount changes annually. Most people will pay the standard premium amount. Please see the Medicare website for more information at: https://www.medicare.gov/your-medicare-costs/part-b-costs

If your modified adjusted gross income is above a certain amount, you may pay an Income-Related Monthly Adjustment Amount (IRMAA). Medicare uses the modified gross income reported on your IRS tax return from two years ago. This is the most recent tax return information provided to Social Security by the IRS. IRMAA is an extra charge added to your premium.

What steps should retirees take to arrange for Cross-Over between UnitedHealthcare and Medicare once they enroll in Medicare?

Upon enrollment in Medicare, the Cross-Over between UnitedHealthcare and Medicare is automatic, forms are no longer required. Medicare Cross-Over assists you in coordinating claim payments between United and Medicare. Medicare will share the claim information with UHC so coordination can occur. You must contact the Center for Medicaid and Medicare Services (CMS) to understand the Coordination of Benefits.

UnitedHealthcare

Questions and Answers About Medicare Cross-Over

These Questions and Answers about Medicare Cross-Over give you an overview of the process.

1) **What is Medicare Cross-Over?**
   Medicare Cross-Over is the process by which Medicare automatically forwards medical claims to UnitedHealthcare for processing. In effect, a Medicare recipient has *one stop shopping* for submitting medical claims and there is no need for you to file twice!

2) **Who can use Medicare Cross-Over?**
   Medicare Cross-Over is available to any Medicare-primary UnitedHealthcare enrollee. That is, Medicare pays first, then claims are submitted electronically to UnitedHealthcare. It is available to both enrollees and their Medicare-eligible dependents, if they do not have group coverage from another source.

3) **How do I enroll?**
   ENROLLMENT IS AUTOMATIC

4) **What claims are included?**
   Medicare Part A and B are included? Prescription drug expenses are not included.

5) **Will Medicare Cross-Over help to speed up the claims payment process?**
   Since UnitedHealthcare will receive claims electronically from Medicare, the claims payment cycle should be shortened. You should receive reimbursement faster! However, any delay by Medicare will result in a delay of the submission of the claim to UnitedHealthcare.

6) **Will my claims be paid differently under this new method?**
   No. The benefits or the plan have not been changed. Only the paperwork has been eliminated for you.

7) **Is there any cost to me for Medicare Cross-Over?**
   No. As a UnitedHealthcare enrollee, you will not be charged for claims processed through Medicare Cross-Over.

8) **How will I know that Medicare has sent my claim to UnitedHealthcare?**
   You may receive an Explanation of Medicare Benefits (EOMB) from your Medicare carrier which will tell you that your claim has been forwarded to your "secondary carrier". (The EOMB may refer to your "secondary carrier" rather than UnitedHealthcare specifically.) If this message does not appear, you will have to submit the claim to UnitedHealthcare yourself.

9) **Doesn't my doctor file claims for me now?**
   Doctors are required to file claims only with Medicare. Even if your doctor does send the bill directly to UnitedHealthcare, the claim cannot be processed until Medicare's payment information is received.

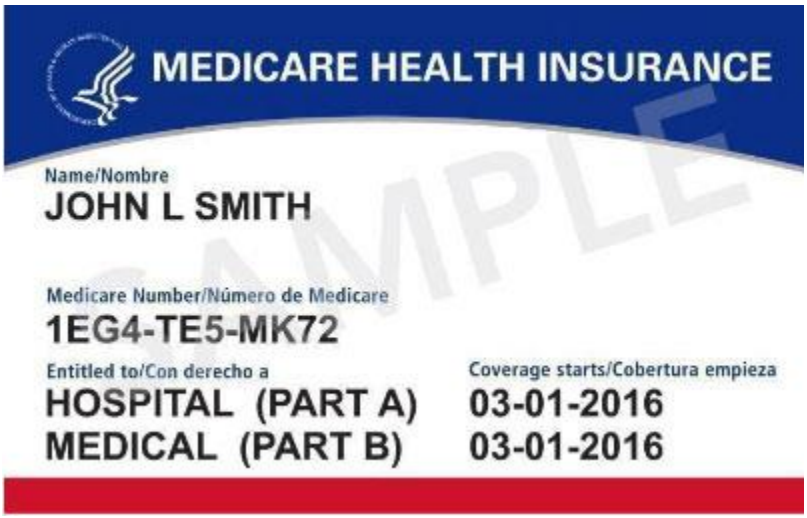
10) **Will I ever need to submit my own claims?**
    Prescription drug expenses will still need to be submitted to UnitedHealthcare or Express-Scripts, depending upon you plan coverage. These types of expense should continue to be filed as they have in the past.

11) If I have a Medicare Cross-Over question concerning my health insurance coverage, whom do I ask?

If you have any questions about anything involving you Medicare claim, call UnitedHealthcare's Customer Care at the number found on the back of your medical ID card. If you have any questions about your primary claim, you should call Medicare.

12) How do I locate my Medicare claim number for the enrollment form?

Please see the following example of a Medicare ID card. You can locate your Medicare claim # on your card. It is the 11-character Medicare number, made up of letters and numbers (on the card below it is 1EG4-TE5-MK72):



Sample Medicare Card

13) Will I be required to accept Medicare coverage if I become disabled and am not yet 65?

Yes, if you are receiving Social Security Disability Insurance (SSDI) benefits for at least 24 months, you will be required to enroll in Medicare earlier than age 65.

14) If required to enroll in Medicare Part B, why was I told that I would keep my benefits for life once retired?

Once you retire, as per Social Security, Medicare benefits become effective for the first of the month in which the retiree and/or spouse turn age 65 or becomes eligible for Medicare. You continue with your PA benefits as secondary to Medicare.

Please note: you need to enroll in Medicare Part A and Part B as soon as you become eligible. If you wait, as a Medicare recipient, you may be assessed penalties for late

enrollment. You are in no way obligated to enroll in the Port Authority's Group Health Insurance Plan. We encourage you to explore Medicare Supplemental Coverage outside of the Port Authority if it meets your financial and health needs.

15) **I recently retired and my spouse is only 62 years old, but UHC says that Medicare should be primary.**
If your spouse is under 65 not receiving Medicare Social Security Disability Insurance (SSDI), and you are Medicare eligible, your spouse will continue to be enrolled in the pre-Medicare UnitedHealthcare Plan until he/she becomes eligible for Medicare.

16) **What happens to my spouse's coverage when I enrolled in Medicare and he/she is not Medicare-eligible?**
If your spouse is under 65 and not enrolled In Medicare Social Security Disability Insurance (SSDI), UnitedHealthcare provides coverage for your spouse through the PPO Plan that provides both in-network and out-of-network benefits.

17) **Why do I have a UHC deductible once I enroll in Medicare?**
When UHC is secondary, you will be responsible for any Co-Pay, Coinsurance, Deductible payments as part of the Coordination of Benefits payments. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense.

18) **How is my Medicare coverage affected if I have coverage of my own with another employer?**
When a retiree becomes eligible for Medicare, coverage with a current employer is primary to the Medicare coverage. You must contact the Centers for Medicaid and Medicare Services (CMS) to understand the Coordination of Benefits.

19) **Will Medicare cover me if I am eligible, but my spouse is employed and has medical insurance with her employer that covers me?**
Your coverage from your spouse will be primary and Medicare coverage will be secondary. You must contact the Centers for Medicaid and Medicare Services (CMS) to understand the Coordination of Benefits.

20) **As a PATH employee and my spouse is Medicare-eligible, do I contact Medicare or Railroad Retirement?**
You will need to contact Railroad Retirement at 877-772-5772.

21) How does my Medical insurance work if I need medical services in a foreign country?

Wile traveling outside of the United States, claims should be submitted directly to UHC for consideration. The plan will consider such charges based upon the out-of-network benefits provisions. Contact Member Services (number located on the back of your UHC ID card) for claim forms and instructions on how to file claims outside of the United States.

22) Will my coverage continue if I decide to live permanently in a foreign country?

If you are permanently living in a foreign country, you will be covered under the UnitedHealthcare out-of-network (Indemnity) plan.

23) Why do I have a $1000 Out-of-Pocket Maximum if I am on Medicare?

The annual Out-of-Pocket Maximum is the highest amount you may be required to pay each calendar year for covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. Your out-of-pocket is reset for the next Plan Year.

24) Why do I have a Medicare deductible once I am on Medicare?

Medicare has a deductible of $240 in 2024. Under the Medicare Plan, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment. This is the portion that a Secondary Insurance Plan (such as Port Authority's plan) will share in the payment of claims. UHC will only pay 80% of the balance 20% for eligible expenses.

25) What is the formula for how much Medicare pays and how much is paid by UnitedHealthcare?

Medicare generally pays 80% of the approved amount for covered services after you pay the applicable annual deductible. For additional information regarding Medicare coverage, you can contact Medicare at 1 800-Medicare.

If you are enrolled in Medicare, UnitedHealthcare will first apply our plan's annual deductible to this amount, and then any covered expenses above the deductible are reimbursed at 80%, leaving a balance of 20% to be paid by the retiree.

26) How will payment be made by Medicare when a physician; 1) accepts Medicare, 2) accepts Medicare but not the allowable charge, or 3) refuses to participate or opts out of Medicare? Will UnitedHealthcare fully reimburse by physician charges in all circumstances?

Generally, there are three different scenarios under which reimbursement will be made:

i) The physician agrees to accept the payment Medicare makes as the allowable charge. If a balance is due and owing after deductibles are satisfied, Medicare will send the balance to UHC for the appropriate percentage payment. You will then receive an Explanation of Benefits which will show what Medicare paid, what UHC paid, and what you may owe.

ii) The physician agrees to participate by treating Medicare patients but does not agree to simply accept the allowable charge. In such a circumstance, Medicare will allow a charge of up to 115% of the Medicare allowable charge. If the balance is due and owing after deductibles are satisfied, Medicare will send the balance to UHN for the appropriate percentage payment. You will then receive an Explanation of Benefits which will show what Medicare paid, what UnitedHealthcare paid and what you may owe.

iii) The physician does not participate and opts out of Medicare. The patient is responsible for paying the physician charges up front. The claim should be submitted to Medicare, once Medicare declines the claim, Medicare will send the denied claim to UHC for the appropriate percentage payment. You will then receive an Explanation of Benefits which will show that Medicare paid "$0", what UHC paid and what you may owe.

Here are examples illustrating the three different scenarios under which calculation of benefits are determined:

	Doctor Accepts Medicare Assignment	**Doctor Does Not Accept Medicare Assignment**
Doctor's Charge	$100	$100
Medicare Approved Amount	$80	$80
Doctor's Revised Charge	$80	$82 (limit=116% of approved amount)
Medicare Payment (80% of approved amount)	$84	$84
Outstanding Balance After Medicare Payment	$16	$28
UHC Plan Pays 80% of Outstanding Balance	$12.80	$22.40
Your Responsibility	$3.20	$8.00

	Doctor Does Not Participate (Opts-out) in Medicare
Doctor's Charge	$100
UHC Applies Estimation of Medicare Part B Benefit at 80%	$80
Outstanding Balance	$20
UHC Pays 80% of Outstanding Balance	$16 (UHC will only reimburse $16 of the $100 charge)
Your Responsibility	$84

Reference in this illustration is not intended to replace definition in any Summary Plan Description booklet.

27) If a provider does not accept Medicare, will UnitedHealthcare cover my claim?

The physician does not participate and opts out of Medicare. The patient is responsible for paying the physician charges up front. The claim should be submitted to Medicare, once Medicare declines the claim, Medicare will send the denied claim to UHC for the appropriate percentage payment. You will then receive

an Explanation of Benefits which will show that Medicare paid "$0", what UHC paid and what you owe.

HEARING BENEFITS

Are hearing aids a covered benefit?

Yes. While Medicare does NOT cover hearing aids or exams for fitting hearing aids, UnitedHealthcare will cover hearing aids up to $2,500 every three years. This is an increase as of 1/1/2024 from the previous coverage of $200. If you are on Medicare, Medicare must receive the invoice for hearing aids first, with the CPT codes, submitted either by your doctor/provider or you. After Medicare processes the claim (either pays or denies) it will forward it to United Healthcare for processing. (For information about Medicare cross-over, and how it coordinates with United Healthcare, see page 9 in these FAQs.

What other types of coverage do I have for hearing treatment?

According to the Medicare 2024 Handbook, Medicare covers hearing and balance diagnostic exams if your doctor or healthcare provider orders them. This is to determine whether you need further medical treatment. You can visit an audiologist once every 12 months without an order from a doctor or other healthcare provider, but only for non-acute hearing conditions (such as hearing loss that occurs typically over many years), and for diagnostic services related to hearing loss, treated with surgically implanted hearing devices. You pay 20% of the Medicare approved amount. The Part B deductible applies. You also pay a co-payment in a hospital outpatient setting.

Note: Medicare doesn't cover hearing aids or exams for fitting hearing aids. Effective 1/1/2024, UnitedHealthcare will cover up to $2,500 annually for hearing treatment (increased from $200/year) such as medical exams, hearing aid exams, services and supplies. See the question above for hearing aids, coverage for which also increased, to $2,500 every three years.

For more information regarding the UHC Plan Coverage, call UnitedHealthcare at 1-877-259-1391 or go to its website at https://www.myuhc.com and use group #197512.

VISION BENEFITS

How do I know if I have coverage for glasses and contact lenses?

Contact National Vision Administrators (NVA) and ask if you are part of a vision plan through the Port Authority or PATH.

Phone: 800-672-7723

Website: https://www.e-nva.com

PA Group #1007

PATH Group #1008

DENTAL BENEFITS

There are a number of dental plans with various eligibilities. Please contact hr_employeebenefits@panynj.gov for information on your plan.

MetLifeDental Form:

https://paranynj.org/paranynj/assets/File/public/benefits/metlife-claim-form.pdf

FOOTCARE BENEFITS

What services are covered under foot care?

Routine care (corns or calluses, cutting and/or trimming of toenails, foot care for flat feet, fallen arches) is only covered if you have a system disease (such as diabetes, neuropathy, etc.). Non-routine foot care I covered for wart removal, surgery, bunions for all individuals.

Does Port Authority participate with Silver Sneakers?

No.

MEDICARE PART B REIMBURSEMENT

What are the requirements to receive Medicare Part B reimbursement?

Eligible Port Authority / PATH retirees are those who:

1) Retired on / after July 1, 2000 who are enrolled in the Port Authority/PATH Group Health Insurance Plans; and
2) Are age 65 or older; and
3) Are retired as a Port Authority/PATH permanent non-represented management or clerical employee, including Field Police (FP) and Police Superiors, or as a member of the FM or FS unions.

This benefit will also be provided to the eligible spouses of the above at age 65, once the retiree reaches age 65.

If you are eligible for Medicare Part B Reimbursement, you will receive correspondence from Health Equity/Wage Works with guidance on how to submit required documentation to obtain your reimbursement. Health Equity/Wage Works can be reached at 877-924-3967 or by going to **https://www.wageworks.com/** to set up your account or to login.

For additional information regarding the Part B Reimbursement please call the Port Authority's Service Delivery for benefits assistance at 212-435-2870 or via email at hr_employeebenefits@panynj.gov.

What is the deadline to submit a claim for my Medicare Part B reimbursement?

The deadline for submitting your Medicare Part B form and documentation to HealthEquity/Wage Works is March 31 of the current year for the prior year. For example: **no later than** March 31, 2023 for calendar year 2022.

I retired in June 1999 with 38 years of service. Why am I not eligible for Part B Reimbursement?

The Medicare Part B Reimbursement Program did not exist prior to July 1, 2000.

Will the Port Authority reimburse the Part D premiums annually if I am eligible for Part B premium reimbursement?

No. Only Medicare Part B premiums are reimbursed to retirees and spouses who meet Port Authority eligibility criteria (see the first question, above).

If I am eligible for the Medicare Part B reimbursement, how do I go about getting it?

Set up an account on https://www.wageworks.com. The documentation you will need to submit a claim depends on your retirement status. See below:

1. You are not yet collecting Social Security benefits, but you are enrolled in Medicare – you would submit copies of your Medicare premium bills; or
2. You receive Social Security (SSA) benefits – you would submit an SSA verification letter, which arrives typically toward the end of November detailing the next year's payments, OR an IRS 1099 form from SSA which arrives typically in January for the preceding tax year; or
3. You receive Railroad Retirement Board benefits – you would submit an RRB verification letter, which arrives typically toward the end of November detailing the next year's payments.

PRESECRIPTION PLAN/MEDICARE PART D

Express-Scripts

Is Express-Scripts coverage Mandatory?

After a retiree enrolls in Medicare, PA Benefits must receive a copy of the retiree's Medicare enrollment card. A retiree will then be enrolled in the Port Authority Retiree Prescription Drug Plan through Express-Scripts (ESI), unless you provide Employee Benefits with written notification that you do not want prescription drug coverage through the Port Authority.

Vaccinations

As of 2004, Express-Scripts has replaced UnitedHealthcare as the benefit provider for vaccination coverage for retirees and their covered dependents. The co-pay is $0 at participating pharmacies. Make sure to present your Express-Scripts ID card. The following vaccines are covered:

- COVID-19
- Flu (seasonal influenza)
- Tetanus, diphtheria, pertussis
- Hepatitis
- Meningitis
- Pneumonia
- Shingles/zoster
- Travel vaccines (rabies, typhoid, yellow fever, etc.)
- Also available: Childhood & Young Adult vaccines (MMR, HPV, etc.)

Express Scripts

Phone: 888-799-6968

TTY users: 800-716-3231

Website: https://express-scripts.com

Medicare Part D

Why am I paying for Medicare Part D premium if I receive Part D-Prescription coverage through Port Authority Express-Scripts?

Although Port Authority retirees do not always share in the premium of their Port Authority sponsored retiree prescription benefits (cost of Port Authority retiree group coverage.) If your income is above a certain limit determined by Social Security, you will pay an income-related monthly adjustment amount in addition to your plan premium. For more information on how Medicare determines the payment requirements, see Medicare's publication: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans

LIFE INSURANCE

I received a letter stating my life insurance benefit has reduced. Why?

Various reasons why your life insurance reduces include:

1. If you have made a voluntary reduction of life insurance coverage.
2. If you have waived your life insurance coverage recently.
3. If you have recently turned 65 and as such per the terms of your collective bargaining agreements, you are only eligible for Insurance Continuation Plan (ICP).

Please contact Prudential Life Insurance regarding your specifics at 800-778-3827.

I make $100,000 and I don't want to pay imputed taxes on my life insurance. Can I drop my life insurance to $50,000?

Yes, but your decision is irrevocable. Please email a written request with you name, ID number and your signature stating that you wish to drop your life insurance to $50,000 to hr_employeebenefits@panynj.gov or mail to HR Service Delivery, 150 Greenwich Street, 16th Floor, New York, NY 10007.

How do I wait my life insurance as a retiree?

Please email a letter with your signature requesting to waive your life insurance to hr_employeebenefits@panynj.gov or mail to HR Service Delivery, 150 Greenwich Street, 16th Floor, New York, NY 10007. Please note that your decision is irrevocable.

Why did my life insurance drop to $20,000 (or $10,000)?

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $10,000 or $20,000, etc. (depending on your Memorandum of Agreement) the amount of the ICP will continue until your death, and you will no longer be required to make contributions.

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