Amy Baluch
Human Resource Director
abaluch@bethlehemschools.org

Bethlehem Central School District
http://bethlehemschools.org

To: Bethlehem CSD Employees Eligible for Health Insurance

From: Amy Baluch, Human Resources

Date: May 1, 2021

Subj: **Open Enrollment for Health Insurance –BPA EMPLOYEES**

OPEN ENROLLMENT runs from May 3 – 28, 2021
This is the only period during which employees may change plans (without a qualifying event).

During the month of May, benefit eligible employees will be able to make changes to health insurance coverage options. These changes include: switching from one plan to another, adding dependents or enrolling in a plan. These plan changes will be effective July 1, 2021. For BCTA members, premium rate changes occur in the two pay periods in June.

The Bethlehem Central School District will provide health insurance benefits in accordance with the appropriate collective bargaining agreements. The employee's contribution rate includes the prescription drug component for all plans which is administered by Blue Shield/Express Scripts. The health insurance contribution rates for 2021-2022 are attached and will also be posted in all buildings and in the staff section of the district website.

<u>If you are not changing your health insurance coverage, adding/deleting dependents or enrolling in a health insurance plan, **no action needs to be taken**.</u> Employees who are making changes must return a completed enrollment form to the Human Resource Office before the appropriate change can be made. It is the responsibility of the employee to complete the enrollment form properly and ensure its receipt by the Human Resource Office no later than May 28, 2021.

Both CDPHP and Blue Shield will be issuing new member cards during this open enrollment period. Blue Shield has a new affiliation that will be on the ID card. They will be known as Highmark Blue Shield of Northeastern New York. CDPHP is updating their member cards as well. There are no changes other than a new card with a new look.

Bethlehem Central High School
Business Office
700 Delaware Avenue
Delmar, NY 12054
(518) 439-7481
(518) 478-0650

BUYOUT: Any employee who is eligible for health insurance and wishes to participate in the health insurance buyout must complete a form **EACH** year. Enrollments do not carry over from year to year and verification of other coverage is required annually. **The form to enroll in the buyout for 2021-22 will be included in a separate email and can also be found on the district website.**

A summary of benefits for the CDPHP MODEL EPO and BS MODEL PPO plans are also included with this memo to assist you with comparison of the plan offerings. The Express Scripts Drug plan has a $5/25/40 copayment structure. The mail order remains 2 copayments for a 90 day supply.

Additional information is available upon request to the Human Resource Office by contacting Amy Baluch at 439-7481, ext. 31926 or by email at abaluch@bethlehemschools.org.

Bethlehem Central Schools

Please Post

HEALTH INSURANCE PREMIUM ANNOUNCEMENT
Effective July 1, 2021 through June 30, 2022

HIRED PRIOR TO 7/1/15

MODEL PLANS EFF 7/1/19

Monthly Rates for Active BPA Employees

MODEL PLAN

Capital District Physicians Health Plan	Monthly Premium	Monthly Employer Share	Monthly Employee Share	Bi-Monthly Paycheck Employee Share
All Principals (BPA)				
Individual Coverage	810.96	$689.32	$121.64	$60.82
2-Person Plan	1,615.90	$1,211.92	$403.98	$201.99
Family (more than 2)	2,139.85	$1,604.89	$534.96	$267.48

EPO-Office Co-Pay: $25
Annual deductible: None

Blue Shield Secure Blue Preferred (PPO)	Monthly Premium	Monthly Employer Share	Monthly Employee Share	Bi-Monthly Paycheck Employee Share
All Principals (BPA)				
Individual Coverage	749.89	$637.41	$112.48	$56.24
2-Person Plan	1,563.92	$1,172.94	$390.98	$195.49
Individual + Dependents	2,170.28	$1,627.71	$542.57	$271.29

In-Network:* *(any participating physician in any location): **No deductible, Co-Pay: $25**
Out-of-Network: (any physician not participating with Blue Shield);
Out of Network Annual deductible: $250 Individual; $500 Family

EXPRESS SCRIPTS DRUG COVERAGE:
(Express Scripts premium is included in each health insurance calculation above.)

ALL PLANS - DRUG COVERAGE :
$5.00-Generic; $25.00-Brand Name; $40.00-Non Formulary

MAIL ORDER - ALL PLANS - DRUG COVERAGE:
$10.00-Generic; $50.00-Brand Name; $80.00-Non Formulary
2 copayments for a 90 day supply

For additional benefit information, please refer to the benefit comparison worksheet.

Bethlehem Central Schools

Please Post

HEALTH INSURANCE PREMIUM ANNOUNCEMENT
Effective July 1, 2021 through June 30, 2022

MODEL PLANS EFFECTIVE 7/1/19

Monthly Rates for Active BPA Employees - Hires as of 7/1/15

MODEL PLAN

Capital District Physicians Health Plan	Monthly Premium	Monthly Employer Share	Monthly Employee Share	Bi-Monthly Paycheck Employee Share
All Principals (BPA)				
Individual Coverage	810.96	$608.22	$202.74	$101.37
2-Person Plan	1,615.90	$1,211.93	$403.98	$201.99
Family (more than 2)	2,139.85	$1,604.89	$534.96	$267.48

EPO-Office Co-Pay: $25
Annual deductible: None

Blue Shield Secure Blue PPO	Monthly Premium	Monthly Employer Share	Monthly Employee Share	Bi-Monthly Paycheck Employee Share
All Principals (BPA)				
Individual Coverage	749.89	$562.42	$187.47	$93.74
2-Person Plan	1,563.92	$1,172.94	$390.98	$195.49
Family (more than 2)	2,170.28	$1,627.71	$542.57	$271.29

In-Network: (any participating physician in any location): No deductible, Co-Pay: $25
Out-of-Network: (any physician not participating with Blue Shield);
Out of Network Annual deductible: $250 Individual; $500 Family

EXPRESS SCRIPTS DRUG COVERAGE:
(Express Scripts premium is included in each health insurance calculation above.)

ALL PLANS - DRUG COVERAGE :
$5.00-Generic; $25.00-Brand Name; $40.00-Non Formulary

MAIL ORDER - ALL PLANS - DRUG COVERAGE:
$10.00-Generic; $50.00-Brand Name; $80.00-Non Formulary
2 copayments for a 90 day supply

For additional benefit information, please refer to the benefit comparison worksheet.

CDPHP ® EPO Plan Benefit Summary

Plan Code: CASHIC321
Group ID: 10001061
Presented For: Bethlehem Central School District
Date Prepared: 10/26/2020
Effective Date: 07/01/2021

	In-Network
Cost Sharing Information	
Deductible	N/A Single / N/A Family
Out of Pocket Maximum	$5,925 Single / $11,850 Family (Embedded)
Office Visits	
PCP	$25 Copayment
Live Video Doctor Visits (24/7 Sick Visits, Behavioral Health, Telenutrition)	$10 Copayment
Specialist	$25 Copayment
Preventive and Well Care Services*	
Well Baby and Child Care including immunizations	Covered in full
Annual Adult Exam (One exam per plan year regardless if 365 days have passed)	Covered in full
Mammography	Covered in full
Annual Pap Test and Ob/Gyn Exam	Covered in full
Prostate Cancer Screening	Covered in full
Bone Density Tests	Covered in full
*Cost sharing may apply to diagnostic care	
Hospital Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	$250 Copayment
Outpatient Surgery	$100 Copayment
Maternity Services*	
Maternity - Routine Prenatal Care and Postnatal Care	Covered in Full*
Maternity - Inpatient Hospital Services	$250 Copayment
Newborn Nursery	Covered in full
*(Non-routine services may result in an additional cost share)	
Emergency Care	
Worldwide Emergency Room Care (waived if admitted inpatient)	$150 Copayment
Ambulance	$150 Copayment
Urgent Care	
Nonparticipating urgent care facility services within the CDPHP UBI service area are not covered	$35 Copayment
Diagnostic Testing*	
Outpatient Hospital or Office Based Laboratory Services: * Copayment waived if provider is a preferred or freestanding laboratory.	$25 Copayment
Outpatient Hospital or Office Based Radiology Services: * Copayment waived if provider is a preferred center.	$25 Copayment
Behavioral Health Services	
Mental Health/Substance Use Inpatient Services	$250 Copayment
Mental Health/Substance Use Outpatient Services	$25 Copayment
*(Up to 20 visits per plan year may be used for substance use family counseling.)	
Condition Support Services	
Outpatient Rehabilitation - Physical Therapy	$25 Copayment (120 visits per benefit period)
Outpatient Rehabilitation - Speech Therapy	$25 Copayment (60 visits per benefit period)
Outpatient Rehabilitation - Occupational Therapy	$25 Copayment (120 visits per benefit period)
Home Health Care	Covered in full

CDPHP ® EPO Plan Benefit Summary

Plan Code: CASHIC321
Group ID: 10001061
Presented For: Bethlehem Central School District
Date Prepared: 10/26/2020
Effective Date: 07/01/2021

	In-Network
Skilled Nursing Facility	Covered in full (90 day limit)
Chemotherapy/Radiation Therapy visit	$25 Copayment
Prosthetic Appliances and Durable Medical Equipment	20% Coinsurance
Diabetic Services	
Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to $100 out of pocket per 30 day supply.	$25 Copayment
Vision Services	
Laser Eye Surgery	Up to a maximum of $750 reimbursement for eligible eye surgeries and consultations per lifetime
Wellness Care	
Weight Management	Up to a $75 reimbursement available for participation in a weight loss program
Fitness Reimbursement	Up to $200 reimbursement per 50 visits for subscriber (max $400 reimbursement per year) and $100 reimbursement per 50 visits for covered dependent (max $200 reimbursement per year)
Child Birthing Classes	Up to $75 reimbursement available for completion of child birthing class
CaféWell Participation	Participating (Up to $180 Life Points per contract per calendar year)
Acupuncture (10 visit limit per plan year for acupuncture services)	$25 Copayment
Nutritional Counseling	$25 Copayment
Chiropractic Benefits	$25 Copayment

This Summary of Benefits is intended to provide a general outline of coverage. In the event of any conflict between this document and the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.

CDPHP UBI gives you access to more than 825,000 participating practitioners and providers nationwide, including many of the major hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

Please Note. All non-emergency services must be provided by a CDPHP Universal Benefits, Inc. ® (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.Please Note. All non-emergency services must be provided by a CDPHP Universal Benefits, Inc. ® (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.

CDPHP ® EPO Plan Benefit Summary

Plan Code: CASHIC321
Group ID: 10001061
Presented For: Bethlehem Central School District
Date Prepared: 10/26/2020
Effective Date: 07/01/2021

Your employer has chosen the following rider(s) to modify the Plan under which you would be covered as a CDPHP Member.

DME Riders	
Rider Name	DME2
Description	Durable medical equipment, prosthetics, orthotics, and oxygen are covered at 20% coinsurance in-network. There is no coverage for orthotic shoe inserts.
Domestic Partnership	
Rider Name	ELG12
Description	Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children.
Medicare Split Family Rider	
Rider Name	ELGMC
Description	Medicare Split Family Rider
Surviving Spouse	
Rider Name	ELG17
Description	Extends eligibility for surviving spouse and dependents upon the death of the subscriber.
Vision Coverage	
Rider Name	VSN2
Description	One routine eye exam is available every 24 months, commencing on the group effective date, without referral, refer to specialist office visit for cost share.

BlueShield
of Northeastern New York

1-800-888-1238 bsneny.com

Benefit Summary for Group:

CASHIC-Bethlehem CSD

Effective Date: 7/1/2021

	PPO 815		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO Network		
Deductible	N/A	$250 single / $500 family	
Deductible Administration Type	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	20% coinsurance after deductible	
Out of Pocket Maximum	$6,850 single / $13,700 family	$2,500 single / $5,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	$5/$25/$40	Not Covered	
Mail Order	2 copays per 90 day supply	Not Covered	

	PPO 815		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	$25 copayment	20% coinsurance after deductible	
Specialist Office Visit	$25 copayment	20% coinsurance after deductible	
Telemedicine	$10 copayment	Not covered	
Allergy Injections	Covered in full	20% coinsurance after deductible	
Allergy Testing	Covered in full	20% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$25 copayment	20% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	$25 copayment	20% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	$25 copayment	20% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$150 copayment	Covered as in-network	Prudent layperson language applies. Emergency Room cost-share waived if admitted; inpatient benefits now apply.
Ambulance	$150 copayment	Covered as in-network	
Urgent Care Center	$35 copayment	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full	20% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	20% coinsurance after deductible	
Immunizations	Covered in full	20% coinsurance after deductible	
Mammogram	Covered in full	20% coinsurance after deductible	
Pap Smear	Covered in full	20% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	20% coinsurance after deductible	
Well Child Visits	Covered in full	20% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	

	PPO 815		
	In-Network	**Out-of-Network**	**Additional Information**
Hospital Services			
Outpatient Surgical Procedure (Facility)	$100 copayment	20% coinsurance after deductible	Prior auth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	120 Days
Diagnostic Testing Services			
Laboratory Tests	$25 copayment	20% coinsurance after deductible	
Radiology	$25 copayment	20% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment/$25 copayment	20% coinsurance after deductible	
Inpatient Maternity	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Outpatient Mental Health	Covered in full	20% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Inpatient Substance Abuse - Detox	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full	20% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	$25 copayment	20% coinsurance after deductible	
Insulin and Other Oral Agents	$25 copayment	20% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay.
Diabetic Medical Supplies (Test strips, Syringes, etc)	$25 copayment	20% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	$25 copayment/$25 copayment	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copayment/$25 copayment	20% coinsurance after deductible	60 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	$25 copayment/$25 copayment	20% coinsurance after deductible	

	PPO 815		
	In-Network	Out-of-Network	Additional Information
Additional Services			
Chemotherapy - Outpatient Facility	Covered in full	20% coinsurance after deductible	
Durable Medical Equipment	Covered in full	50% coinsurance after deductible	
Home Health Care	$25 copayment/$25 copayment	20% coinsurance after deductible	100 Visits IN & OON
Hospice	$25 copayment/$25 copayment	20% coinsurance after deductible	210 days INN & OON
Prosthetics & orthotics	Not covered	Not covered	
Dialysis	Covered in full	20% coinsurance after deductible	
Wellness Card	Not covered	Not covered	
Pediatric Vision Services			
Routine Exam	Covered in full	OON Services reimbursement by vendor. after deductible	1 every calendar year
Medical Eye Exam	$25 copayment/$25 copayment	20% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	OON Services reimbursement by vendor. after deductible	1 every calendar year
Medical Eye Exam	$25 copayment/$25 copayment	20% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

***This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.

Bethlehem CSD
Express Scripts Prescription Drug Plan

	Generic Drug	Brand Name Drug	Non-Formulary Generic & Brand Name Drug
Retail Copayment	$5	$25	$40
Mail Order Copayment (90 day supply)	$10	$50	$80
Providers	*Member must utilize a participating Medco Pharmacy provider.*		

CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Dr West, Albany, NY 12205 - (518) 689-1555, emorrissette@amsure.net

GROUP NAME ____________

SECTION A

Last Name | First | M.I.

Address | County

City | State | Zip Code

Your Social Security No. ___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Marriage ___/___/___ Date of Divorce ___/___/___

Phone No.: (______)__________ (______)__________

Employment Status: ☐ FT ☐ PT Hrs/Weekly_____ ☐ Active ☐ Retired ☐ COBRA

Hire Date ___/___/___ Status Chg Date ___/___/___

EMPLOYER USE ONLY

Effective Date ___/___/___

Retire Date ___/___/___

Grp No.__________

Loc. Code__________

SECTION B

☐ Open Enrollment (complete Section D)
☐ New Enrollment/Reinstatement (complete Section D)
☐ Change Coverage to (check new coverage)
☐ Cancel Coverage (check what applies)
☐ Add/Delete Dependent (complete section D)
☐ Information Change (complete Section A)
☐ Waive Coverage (must provide proof of Insurance)
☐ NYS Dependent Coverage up to Age 29

	Carrier	Tier
Indem/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
PPO/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
POS/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
CDPHP EPO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
MVP HMO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Rx		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Dental		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Other		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr

Reason/Comments:

SECTION C

Other Coverage?

Is there coverage under any other group health plan available to you or any of your covered dependents?

☐ **Yes** ☐ **No**

If Yes; Policyholder Name | Relationship ☐ Self ☐ Spouse ☐ Child

Social Security Number ___/___/___ | Birth Date ___/___/___

Insurance Co. Name | Policy #

Plan Type ☐ Self only ☐ Self/Spouse ☐ Self/Child(ren) ☐ Fam

Coverage Type ☐ Health ☐ Drug ☐ Dental ☐ Vision

SECTION D

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS * (See Dependent Verification Requirement Below)

ADD	DELETE	Relationship	Last	First	M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date (Copy of Medicare card required)	Primary Care Physician (PCP) (MVP HMO & BS POS ONLY)
☐	☐	**Self** ☐ M ☐ F				___/___/___	n/a	___/___/___	___/___/___ ___/___/___	
☐	☐	**Spouse/DP** ☐ M ☐ F				___/___/___	n/a	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter				___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter				___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter				___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter				___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	

SECTION E

Do your dependents reside in your home? ☐ Yes ☐ No

If No, give address:__________

Do you have a disabled dependent beyond age 19? ☐ Yes ☐ No

List name(s):__________

Full-time college students age 19 and over (Dental Only):

List Names: | School Name and Address:

Dependent Verification*

School District Representative (SDR) ______ (please initial)

Date: __________

* The SDR by initialing above affirms that they have received and reviewed the required dependent verification documentation, and that the dependents for whom this applicant is requesting coverage meet the minimum standards for dependent coverage established by this district and the Capital Area Schools Health Insurance Consortium (CASHIC).

Applicant's Signature: __________

Date: __________

Employer's Signature: __________

Date: __________

White Copy – AMSURE Yellow Copy – EMPLOYER Pink Copy – EMPLOYEE

Dependent Verification Checklist

Below is a list of eligibility rules and documents required to verify your dependent(s). In most cases at least TWO forms of documentation are required for dependents. Please read carefully.

ID	Dependent Type	Age	Eligibility Requirements
LS	**Legal Spouse**	N/A	• The covered participant's husband or wife under Federal or State Law

Document Option for Verifying Eligibility:

Government Issued Marriage Certificate AND Federal Tax Return Within Last 2 Years

OR

Government Issued Marriage Certificate AND Proof of Joint Ownership (i.e. Lease Agreement, Mortgage, Utility Bill, etc.) Issued Within Last 6 Months

OR

Government Issued Marriage Certificate Only (if married in the last 12 months)

CLS **Common Law Spouse** N/A

Only allowable in the following states, according to the criteria listed below:

- Alabama
- Colorado
- Georgia (if created before 1/1/97)
- Idaho (if created before 1/1/96)
- Illinois
- Iowa
- Kansas
- Montana
- New Hampshire (for inheritance purposes only)
- Ohio (if created before 10/10/91)
- Oklahoma (if created before 11/1/98)
- Pennsylvania (if created before 1/1/05)
- Rhode Island
- South Carolina
- Texas
- Utah
- Washington, D.C.

Document Options for Verifying Eligibility:

Affidavit of Common Law Marriage AND Proof of Joint Ownership Issued Within Last 6 Months

OR

Affidavit Of Common Law Marriage AND Federal Tax Return Issued Within Last 2 Years

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DP **Domestic Partner** Age 18 and over- Same/Opposite Sex

- You and your DP are at least 18 years of age and capable of consenting to the relationship
- You and your DP are not related to one another to a degree that would prevent marriage under the laws of the state you reside in
- Neither you nor your DP is married to another person under statutory/common law or in another DP relationship
- You and your DP have been in a single, dedicated relationship for a minimum of 6 consecutive months
- You and your DP share the same residence for a minimum of 6 consecutive months

Document Options for Verifying Eligibility:

Proof that you and your partner have resided together for at least six (6) months (i.e. Lease Agreement, Mortgage, Utility Bill, etc.) AND Registration as a domestic partner in the municipalities that have established such a procedure (New York City, Rochester, Ithaca, etc.)

OR

Proof that you and your partner have resided together for at least six (6) months (i.e. Lease Agreement, Mortgage, Utility Bill, etc.) AND Proof of Financial Interdependence (i.e. Bank Statement, Tax Return, etc.)

BC **Biological Child**

- Must be the biological child of the participant

Document Option for Verifying Eligibility:

Government Issued Birth Certificate

DBC **Disabled Biological Child** Age 26 and over

- Must be the biological child of the participant
- Must be unmarried
- Must be medically certified as disabled
- Must be financially supported by the participant and spouse

Document Options for Verifying Eligibility:

Government Issued Birth Certificate AND Federal Tax Return Within Last 2 Years (Claiming Child)

AC **Adopted Child** Age 25 and under

- Must be the adopted child of the participant

Document Options for Verifying Eligibility:

Adoption Placement AND Petition for Adoption **OR** Adoption Certificate

ID	Dependent Type	Age	Eligibility Requirements
DAC	**Disabled Adopted Child**	Age 26 and over	• Must be the adopted child of the participant • Must be unmarried • Must be medically certified as disabled • Must be financially supported by the participant and spouse
	Document Options for Verifying Eligibility: Adoption Certificate AND Federal Tax Return Within Last 2 Years (Claiming Child)		
SC	**Step-Child**	Age 25 and under	• Must be the biological child of the participant's spouse
	Document Options for Verifying Eligibility: Government Issued Birth Certificate, Government Issued Marriage Certificate, AND Federal Tax Return Within Last 2 Years (Claiming Child) **OR** Government Issued Birth Certificate AND Government Issued Marriage Certificate (if married within the last 12 months) **OR** Government Issued Birth Certificate, Affidavit of Common Law Marriage, AND Proof of Joint Ownership Issued Within Last 6 Months **OR** Government Issued Birth Certificate, Affidavit of Common Law Marriage, AND Federal Tax Return Within Last 2 Years (Claiming Child) **OR** Government Issued Birth Certificate, Government Issued Marriage Certificate, AND Proof of Joint Ownership Issued Within Last 6 Months		
DS	**Disabled Step-Child**	Age 26 and over	• Must be the biological child of the participant's spouse • Must be unmarried • Must be medically certified as disabled • Must be financially supported by the participant and spouse
	Document Options for Verifying Eligibility: Government Issued Birth Certificate, Government Issued Marriage Certificate, AND Federal Tax Return Within Last 2 Years (Claiming Child) **OR** Government Issued Birth Certificate, Affidavit of Common Law Marriage, AND Federal Tax Return Within Last 2 Years (Claiming Child)		
LW	**Legal Ward**	Age 25 and under	• Must be the legal ward of the participant
	Document Options for Verifying Eligibility: Government Issued Birth Certificate AND Court Ordered Document of Legal Custody		
DW	**Disabled Legal Ward**	Age 26 and over	• Must be the legal ward of the participant • Must be unmarried • Must be medically certified as disabled • Must be financially supported by the participant and spouse
	Document Options for Verifying Eligibility: Government Issued Birth Certificate, Court Ordered Document of Legal Custody AND Federal Tax Return Within Last 2 Years (Claiming Child)		