



INFORMATION ANNOUNCEMENT

Andrew M. Cuomo
Governor

RoAnn M. Destito
Commissioner

NYSHIP Opt-Out 2013 Program

Effective January 1, 2013, the New York State Health Insurance Plan (NYSHIP) will again offer the Opt-Out Program. This program allows eligible employees represented by CSEA, PEF, NYSCOPBA, Council 82 and Management/ Confidential employees who have other employer sponsored group health insurance, to opt-out of their NYSHIP coverage in exchange for an incentive payment.

For purpose of the Opt-out Program, other employer sponsored group health insurance coverage means coverage through employment other than employment with the executive, legislative or judicial branch of state government, including the State University of New York. Therefore, **if the other coverage is through another state employee or retiree, the employee is not eligible for the opt-out.**

Eligibility

To be eligible for the Opt-Out Program, an employee must meet the eligibility criteria below to receive the incentive payment:

1. The employee must currently participate in the Opt-Out Program; or
2. The employee must have been enrolled in NYSHIP, continuously and in his/her own right, as a state employee, on April 1, 2012 or on the date **first eligible for NYSHIP** if that date is after April 1, 2012 through the end of the year.
3. The employee must provide plan information and attest to having other employer sponsored group health insurance coverage in effect as the opt-out effective date.

Additional Eligibility Rules for New York State Employees Represented by CSEA

In addition to the eligibility requirements for the NYSHIP Opt-Out Program described above, the following additional information applies to CSEA represented employees only. Both the CSEA represented employee **and** the spouse or domestic partner who is a state employee must be enrolled in a state plan **in his/her own right** in order to satisfy the first additional eligibility rule described below:

1. A CSEA represented employee who has a spouse or domestic partner who is a state employee, whether that spouse or domestic partner is a CSEA represented employee, represented by another state employee union, an M/C employee or an employee of the legislature or the Unified Courts System and both are covered by NYSHIP (dual enrollment), may elect to opt out and receive \$1,000 for calendar year 2013 whether the CSEA represented employee is opting out of individual or family coverage; and
2. Both employees must have been enrolled in a state plan by April, 1, 2012 to elect the Opt-Out Program for calendar year 2013.

Opting-out for Employees Currently Enrolled in NYSHIP

Employees who are currently enrolled in NYSHIP and wish to participate in the Opt-Out Program must elect to opt out during the Annual Option Transfer Period and must complete a **PS 409 Opt-Out Attestation Form** and a **PS 404 NYS Health Insurance Transaction Form**. The actual effective date of the opt-out (i.e., the date NYSHIP

will no longer be in effect) will be January 3, 2013.

Opting-out for Newly Eligible Employees

1. An employee who is newly eligible to enroll in NYSHIP and wishes to participate in the Opt-out Program must make the election no later than the first date of his/her effective date for NYSHIP benefits (after 42 or 56 days waiting period has been satisfied). A newly eligible employee is one who was not previously eligible for NYSHIP benefits as an employee of New York State. An employee of New York State is an individual employed by the Executive, Legislative or Judicial branch of State government, including the State University of New York, or;
2. An employee who is newly eligible for the Opt-out Program as the result of a change in bargaining unit may elect to participate in the Program within 30 days of the effective date of the bargaining unit change. An employee who is transferring from one State agency to another is not newly eligible unless the employee was previously working in a non-benefits eligible position or in a bargaining unit not eligible for the Opt-out Program.

A newly eligible employee must complete both a **PS-409-Opt-out Attestation Form** and a **PS-404-NYS Health Insurance Transaction Form**.

Employees Currently Participating in the Opt-out Program for 2012

State employees who currently participate in the Opt-Out Program for 2012 **must** submit both **PS 409-Opt-Out Attestation Form** and a **PS 404 New York State Health Insurance Transaction Form** to re-enroll for the 2013 calendar year. **If they fail to submit the required documents during the Annual Option Transfer Period, their opt-out payments will end with the last bi-weekly payroll check for the plan year 2012.**

Incentive Payments

The annual incentive amount for opting out of NYSHIP coverage is \$1,000 for individual coverage or \$3,000 for family coverage (unless otherwise explained in additional eligibility rules). The incentive payments will be prorated and reimbursed through the employee's biweekly paychecks throughout the year (payable only when an employee is on the payroll and meets the requirements to be eligible for the state to contribute to the cost of NYSHIP coverage).

The incentive amount will be credited to the employee's bi-weekly payroll check and will be treated as taxable income. The bi-weekly incentive amounts will be \$38.47 for opting out of Individual coverage (\$1,000/26 paychecks) or \$115.39 for opting out of Family coverage (\$3,000/26 paychecks).

Changes Affecting Opt-out Program Eligibility

1. An employee loses eligibility for participation in the Opt-Out Program during any period when:
 - The employee is no longer employed in a benefits eligible position; or
 - The employee no longer meets the requirements for the state to contribute to the cost of NYSHIP coverage; or
 - The employee is no longer in a position assigned to a bargaining unit eligible for the Opt-Out Program.

If an employee loses eligibility for the Opt-Out Program temporarily because of being off the payroll, experiencing a reduction of hours or being on leave, the employee will automatically resume participation in the Opt-Out Program for the remainder of that year upon regaining eligibility.

2. An employee receiving the incentive for opting out of family coverage whose last dependent loses NYSHIP eligibility, will only be entitled to the Individual incentive payment, effective on the date the dependent loses eligibility.

Re-enrollment in NYSHIP

Employees who participate in the Opt-Out Program may re-enroll in NYSHIP during the next Annual Option Transfer Period. To re-enroll in NYSHIP coverage at any other time, employees must experience a qualifying event, such as a change in family status (i.e.; marriage, birth, death or divorce) or loss of the other employer sponsored group health insurance. Employees must complete a **PS 404 Health Insurance Transaction Form** within 30 days of the date of the qualifying event and provide proof of the qualifying event or the re-enrollment will be subject to NYSHIP's late enrollment rules. *See the NYSHIP General Information Book for details on late enrollment waiting periods.*

Retirement While In the Opt-Out Program

Participation in the Opt-Out Program is considered participation in NYSHIP for purposes of establishing eligibility for NYSHIP coverage in retirement. Retirees are not eligible for the Opt-Out Program, so participation terminates when the employee's eligibility for NYSHIP coverage as an active employee ends.

Completed PS-404 Health Insurance Transaction and PS-409-the Opt-out Attestation can be mailed to NYS OGS – Business Service Center, Empire State Plaza, Corning Tower, 32nd Floor, Albany, NY 12242 or faxed to the Business Service Center, Benefits Unit at (518) 486-9166.

If you have any questions, please contact the Benefit Unit at the Business Service Center (518) 457-4272.

For more information visit the BSC website or contact the BSC today!

Email: bsc@ogs.ny.gov
Website: <https://bsc.ogs.ny.gov>

Tel: 518-457-4272
Fax: 518-486-9166

BSC Finance (31st Floor) & HR (32nd Floor)
Corning Tower, Empire State Plaza
Albany, NY 12242

10. Continued. ENTER REQUEST(S) BELOW

H. Change NYSHIP Option Change to: Empire Plan HMO Code HMO Name _____ Opt-Out

I. Change Pre-Tax Status Change to: Pre-Tax Post-Tax Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)

11. PREVIOUS COVERAGE INFORMATION

| | | | | |
|--|--|------------------------------------|-------|----------------|
| If you were previously enrolled in a NYSHIP plan, or were covered another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section. | Previous ID Number | Date the other coverage terminated | | |
| | Enrollee's Name Under Which Previously Covered | Last | First | Middle Initial |

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage. Medical Dental Vision

I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll. Medical Dental Vision

RETIREMENT

I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. (A completed PS-406.2 must be attached.)

13. REQUEST FOR EMPIRE PLAN CARD ONLY

For Health Maintenance Organization (HMO) cards, contact your HMO.

DUPLICATE CARD (Previously issued card remains valid.) **FOR** ENROLLEE
 ENROLLEE AND ALL DEPENDENTS
 INDIVIDUAL DEPENDENT
Name _____

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. I hereby **authorize deduction from my salary or retirement allowance** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature (**Required**) _____ Signature Date (**Required**) _____

AGENCY/EBD USE ONLY

| Action/Reason | Date of Event | Hire Date | Date of 1 st Eligibility (PE only) | Percentage Working | Agency Code | Neg. Unit | Ret. System |
|---------------|---------------|-----------|---|--------------------|-------------|-----------|-------------|
| | | | | | | | |

| Retirement Tier | Registration # | Sick Leave Information | | Date Entered on NYBEAS | Effective Date |
|-----------------|----------------------|------------------------|--------------------|------------------------|----------------|
| | | # Hours | Hourly Rate of Pay | | |
| | <input type="text"/> | | | | |

HBA Signature: _____ **Date:** _____



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| Boxes 1 - 9 | All enrollees must complete boxes 1 – 9 with their personal information. Note: Marital Status Date is used to show date of marriage, separation or divorce when those marital statuses are selected. |
|--------------------|---|

| | |
|-----------------------|---|
| Box 10 (A – I) | <p>Complete appropriate sections. The employee is entitled to make separate choices regarding their medical, dental and vision coverages. They may decline any of the three, all of the three, or none of the three different coverage options. Also, they may enroll in family coverage in one benefit and individual coverage in another.</p> <p>Reminder: Enrollees with a Benefit Fund (CSEA, UUP and DC-37) receive their dental and vision benefits through that Fund. Do not enter dental and vision information on NYBEAS for these enrollees.</p> |
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New Enrollees (also complete 10.G for family coverage)

Note: for new enrollments in a Health Maintenance Organization (HMO), complete an HMO form in addition to this form.

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|------|---------------------------------|--|
| 10.A | Request Enrollment – Individual | Check box to enroll in individual coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled. |
| 10.B | Request Enrollment – Family | Check box to enroll in family coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled. |
| 10.C | Elect Pre-Tax Status? | New Enrollees choose to enroll in or decline the Pre-Tax Contribution Program for medical coverage. |
| 10.D | Decline Coverage | Check box to decline coverage. Check Medical, Dental and/or Vision boxes for coverage being declined. |

Cancellation or Change in Coverage

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| 10.E | Voluntarily Cancel Coverage | The enrollee is entitled to make separate decisions regarding their medical, dental and vision coverages. Enrollees may cancel or change their dental and/or vision coverage(s) at any time during the year. Pre-tax medical enrollees may only cancel coverage during the Pre-Tax Open Enrollment Period, or with a qualifying event (enter the qualifying event). If you are going on Leave Without Pay, also complete Box 12. |
| 10.F | Change Coverage | Check this box to change from Individual to Family, or from Family to Individual coverage. Pre-tax medical enrollees may only change their coverage from Family to Individual during the Pre-Tax Open Enrollment Period, or with a qualifying event (check the qualifying event and enter the Date of Event). Check Medical, Dental, and/or Vision boxes for coverage being changed. |
| 10.G | Add/Change/Delete Dependents | Check the box to add or delete dependents or to change dependent information. Check Medical, Dental, and/or Vision boxes that apply. Complete all dependent information including date of birth. Additional documentation may be required to add the dependent. |
| 10.H | Change Medical Benefit Plan | Complete during annual Option Transfer Period or with a qualifying event (for example, change of address outside of HMO area.) |
| 10.I | Change Pre-Tax Status | Existing enrollees can only change pre-tax status during the annual Pre-Tax Open Enrollment Period in November. |



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| Box 11 | Complete previous coverage information, if applicable. |
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| | | |
|---------------|----------------------------------|---|
| Box 12 | LEAVE WITHOUT PAY SECTION | Enrollees going on leave without pay who request cancellation of coverage at the time they leave the payroll must complete this section. To request permanent cancellation of coverage, check the appropriate box and cross out the sentence which reads "I wish to resume my coverage upon return to the payroll." |
| | RETIREMENT SECTION | Enrollees leaving the payroll due to retirement must complete this section to indicate their decision to either defer or continue health insurance coverage as a retiree. A PS-406.2 must be completed for enrollees requesting deferment of medical coverage, prior to retirement. |

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| Box 13 | Request for Empire Plan Cards Only – complete this section to order a duplicate or replacement Benefit Card. Do not complete this section if requesting a change to your health insurance coverage. A new card will be issued automatically. |
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| AUTHORIZATION | Employees must SIGN and DATE this form. |
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|---|--|
| AGENCY/EBD USE ONLY | This section is for Agency and/or EBD use only and is provided to assist in updating the enrollee's record on NYBEAS. |
| Action/Reason | Transaction that will be inputted into NYBEAS by HBA. |
| Date of Event | Date the event took place, which resulted in the enrollee requesting a change to benefits. Example: first day worked, first day on leave, date of birth, date of marriage. |
| Hire Date | Original date of hire or rehire. (Only needed for new enrollment). |
| Date of 1 st Eligibility (PE only) | The first day the enrollee is eligible for coverage. |
| Percentage Working | Enrollee's percentage on payroll. |
| Agency Code | Enrollee's agency code. |
| Neg. Unit | Enrollee's negotiating unit. |
| Ret. System | The retirement system for the enrollee (ERS, TRS or PFS) |
| Retirement Tier | Tier 1, 2, 3 or 4. |
| Sick Leave Information - # Hours | Number of sick leave hours for enrollee at time of retirement. |
| Sick Leave Information - Hourly Rate of Pay | Enrollee's hourly rate of pay based on annual salary at the time of retirement. (See Hourly Rate Calculation memo NY99-22). |
| Date Entered on NYBEAS | Date HBA processes the transaction on NYBEAS. |
| Effective Date | The effective date assigned to the transaction by NYBEAS. |

Note: When updating NYBEAS, use **Date** in **Authorization Box** as **Date of Request**.

Legal changed

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

| Employees | Spouse/Domestic Partner | Children |
|------------------------------|--|--|
| Copy of Birth Certificate | Copy of Birth Certificate | Copy of Birth Certificate |
| Copy of Social Security Card | Copy of Social Security Card | Copy of Social Security Card |
| | Copy of Marriage Certificate or Complete PS-425 series Domestic Partner, if Applicable | Completed PS-451 – Statement of Disability and Required Documentation, if Applicable |
| | For Changes of Coverage, copy of Marriage Certificate, Divorce Order, Death Certificate, PS-425.4 (Domestic Partner), as appropriate | Completed PS-457 – Statement of Dependence and Required Documentation, if Applicable |



State of New York
Department of Civil Service
Albany, NY 12239

**EMPLOYEE BENEFITS DIVISION
2013 OPT OUT ATTESTATION FORM**

PS 409 (10/12)

EMPLOYEE INFORMATION

| | | | | | |
|---|--|---|------------------------------------|-------------------------|-------|
| Name | | Social Security Number | | Negotiating Unit | |
| Street Address | | | City | | State |
| | | | | | Zip |
| Date of Birth ____/____/____ | | Telephone Numbers Home () Work () | | Agency Name and Address | |
| Marital Status <input type="checkbox"/> Single | | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | | |
| | | <input type="checkbox"/> Widowed | <input type="checkbox"/> Separated | | |

NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

Complete this section if you are newly eligible or currently enrolled in NYSHIP.

Employees must attest below that they are covered under other employer-sponsored group health insurance coverage other than the State of New York as of the opt out effective date, to be eligible for the Opt-out Program (CSEA employees, see your HBA for additional eligibility information).

Check one:

- I am electing to opt out of Individual coverage in exchange for a \$1,000 taxable amount.
- I am electing to opt out of Family coverage in exchange for a \$3,000 taxable amount (dependent information must be provided when electing Family opt-out).

Other employer-sponsored group health insurance information (must be provided)

Name of covered employee _____ Covered employee's Date of Birth _____

Covered employee's SSN _____ Name of covered employee's employer _____

Effective date of alternate health insurance coverage _____

Name and Address of alternate health insurance coverage _____



ATTESTATION

All employees complete this section

I have read the Opt-out Program materials and instructions and I attest to the following:

- I am covered under another employer-sponsored group health plan other than the State of New York that is in effect as of the opt out effective date and have provided my alternate plan information.
- I understand that I must promptly report changes to information I have provided above which may impact my eligibility.
- I understand that I may choose to opt out of Family coverage *only* if I have NYSHIP eligible dependents.
- I understand that this election is for 2013 only.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

Employee's Signature (Required) _____ Signature Date (Required) ____/____/____

Employees who can demonstrate and attest to having other employer-sponsored group health insurance may elect to opt out of NYSHIP's Empire Plan or Health Maintenance Organizations. Employees who elect to opt out of NYSHIP will receive \$1,000 for waiving Individual coverage or \$3,000 for waiving Family coverage. This amount will be credited to bi-weekly paychecks as taxable income over the plan year. Unless newly eligible to enroll, employees must be enrolled in NYSHIP Individual or Family coverage prior to April 1st of the previous plan year to be eligible to opt out of that coverage. This enrollment cannot have been subject to late enrollment. In order to participate, employees must have other employer-sponsored group health insurance.

There are two circumstances when employees may elect to opt out of coverage; as newly eligible for the Opt-out Program, and, for currently enrolled employees, during the Annual Option Transfer Period. Only employees who experience a qualifying event will be allowed to withdraw their Opt-out election and enroll in a health insurance plan mid-year. See instructions below.

INSTRUCTIONS:

Newly eligible employees: Employees may enroll in the Opt-out Program no later than their first date of NYSHIP eligibility. Employees must sign the PS-409 Opt-out Attestation Form and complete a PS-404 Enrollment Form.

Current enrollees: Eligible enrollees may elect the Opt-out Program during the Annual Option Transfer Period for each plan year. Employees must sign the PS-409 Opt-out Attestation Form and complete a PS-404 Enrollment Form.

During mid-year: Employees who experience a Qualifying Event (QE) must notify their personnel office within thirty (30) days of the QE date in order to enroll in a health insurance plan without a waiting period. Employees must complete a PS404 Enrollment Form.

By signing the Opt-out Attestation, you elect to receive \$3,000 (Family coverage waived), or \$1,000 (Individual coverage waived); this amount will be credited to your bi-weekly paycheck as taxable income over the plan year.

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.

This form is invalid if it is not signed and submitted along with a completed PS 404.