



INFORMATION ANNOUNCEMENT

Andrew M. Cuomo
Governor

RoAnn M. Destito
Commissioner

2014 NYSHIP Opt-out Program for PEF, NYSCOPBA, Council 82, and M/C Employees

The New York State Health Insurance Program (NYSHIP) will again offer the Opt-out Program for plan year 2014. 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.

Please note that opt-out information for CSEA represented employees is addressed in a separate announcement.

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 New York 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.

Opt-out Program Provisions

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, 2013 or on the date first eligible for NYSHIP if that date is after April 1, 2013, through the end of the year for all periods of time for which the employee is eligible for employee-share premiums; and
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.

Opting-out for Employees Currently Enrolled in NYSHIP in a Health Insurance Option

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 an Opt-out Attestation Form (PS-409) and a NYS Health Insurance Transaction Form (PS-404). The actual effective date of the Opt-out Program (i.e., the date NYSHIP coverage will no longer be in effect) will be January 2, 2014.

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 the Opt-out Attestation Form (PS-409) and a NYS Health Insurance Transaction Form (PS-404).

Employees Currently Participating in the Opt-Out Program for 2013

The Opt-out Program does **not** automatically renew each year. NYS employees who currently participate in the Opt-out Program will receive a notice from the Employee Benefits Division along with a Health Insurance Transaction Form (PS-404) electing the Opt-out Program and the Opt-out Attestation Form (PS-409), which must be submitted to the BSC Benefits Unit. If an employee 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 plan year 2013.

Incentive Payments for the Opt-out Program

The annual incentive amount for opting out of NYSHIP coverage is \$1,000 for Individual coverage or \$3,000 for Family coverage. 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).

Incentive payments to employees participating in the Opt-out Program for 2014 will begin coincident with the plan year's rate change.

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 (e.g.; marriage, birth, death or divorce) or loss of the other employer sponsored group health insurance. Employees must complete a Health Insurance Transaction Form (PS-404) 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.

If you have any questions regarding the Opt-out Program, please contact the BSC Benefits Unit at (518) 457-4272 or e-mail BSCBenefitsAdmin@ogs.ny.gov.

Health Insurance Transaction Form (PS-404) and the Opt-out Attestation Form (PS-409) can be mailed to:

OGS-BSC Benefits Unit
540 Broadway, 3rd Floor
Albany, NY 12207

Or faxed to:
(518) 486-9166

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

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

BSC Benefits Unit
540 Broadway, 3rd Floor
Albany, NY 12207



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). **Forms can be faxed to OGS-BSC Benefits at (518) 486-9166 or mailed to BSC Benefits Unit, 540 Broadway, 3rd Floor, Albany, NY 12207.**

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 2014 only.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

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

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 am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. **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		
	<input type="text"/>	# Hours	Hourly Rate of Pay				

HBA Signature: **Date:**