NYC HEALTH+ HOSPITALS

Opt-Out of HIP HMO Coverage

In pursuant to the NYC Health Benefits Summary Program Description established by the Office of Labor Relations, employees that were hired on or after October 1, 2022 will only be eligible to enroll into the **HIP HMO** Plan.

If you are your eligible dependent is being treated by a non-network providing for a life threatening or disabling disease or condition or have an illness that requires complex management, you have the ability to request to Opt-Out of the HIP HMO Coverage.

To request to Opt-Out of the HIP HMO Plan, you will need to complete an **Opt-Out Request Form.**

Once the form is completed please forward the form to the following:

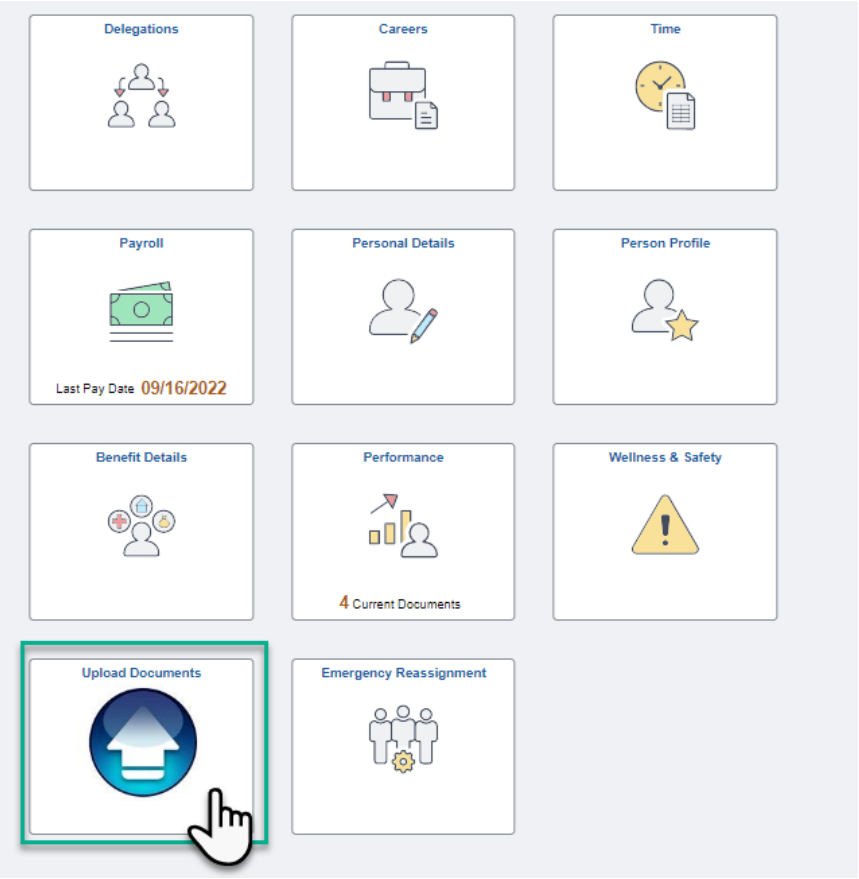
Email: cityagencies@emblemhealth.com

Fax: 212-510-5445

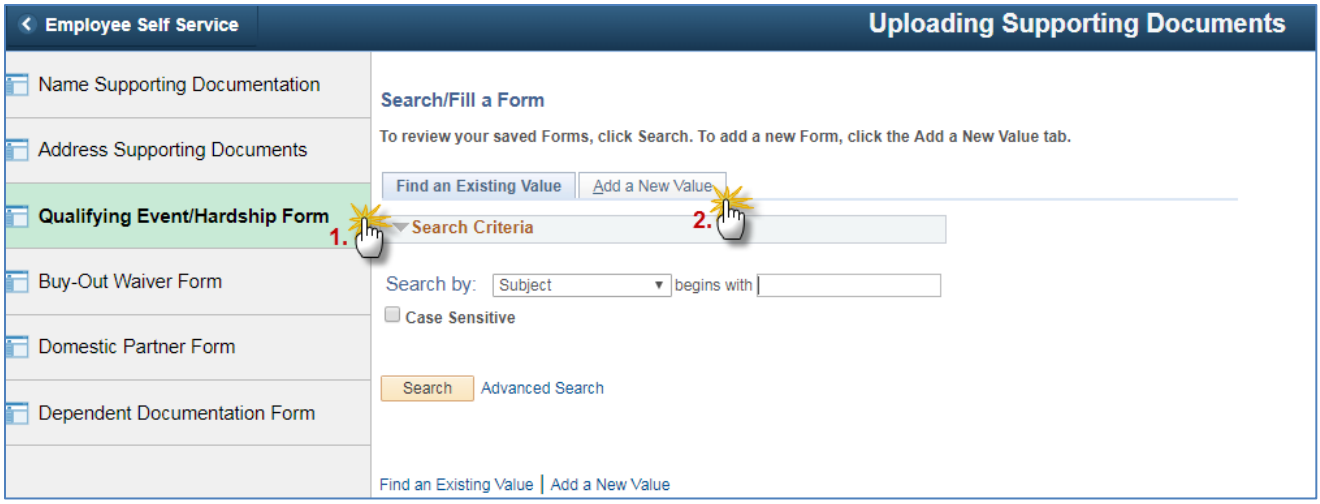
Address: Attn: EmblemHealth

Opt-Out Form Processing Department
55 Water Street New York, NY 10041

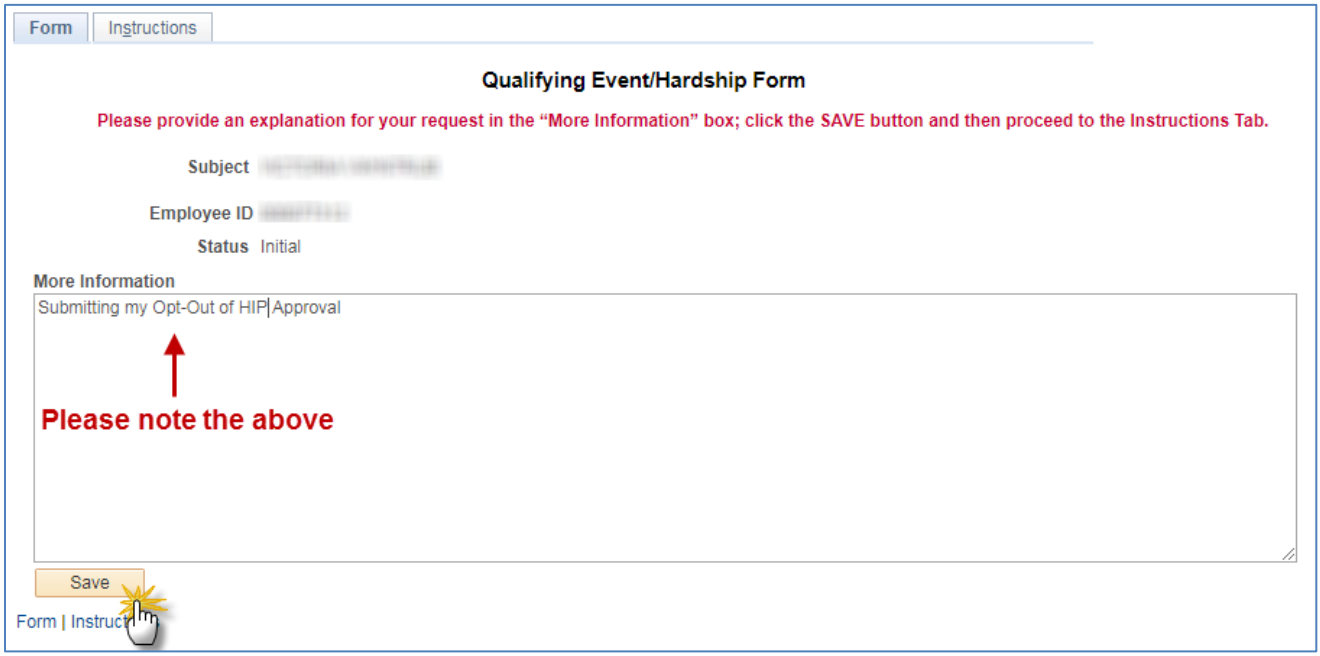
Once an **approval** has been granted, you will need to submit this approval into PeopleSoft, by logging in and navigating to **Uploading Supporting Documentation**



Continue by clicking on **Qualifying Event Hardship > Add a New Value**

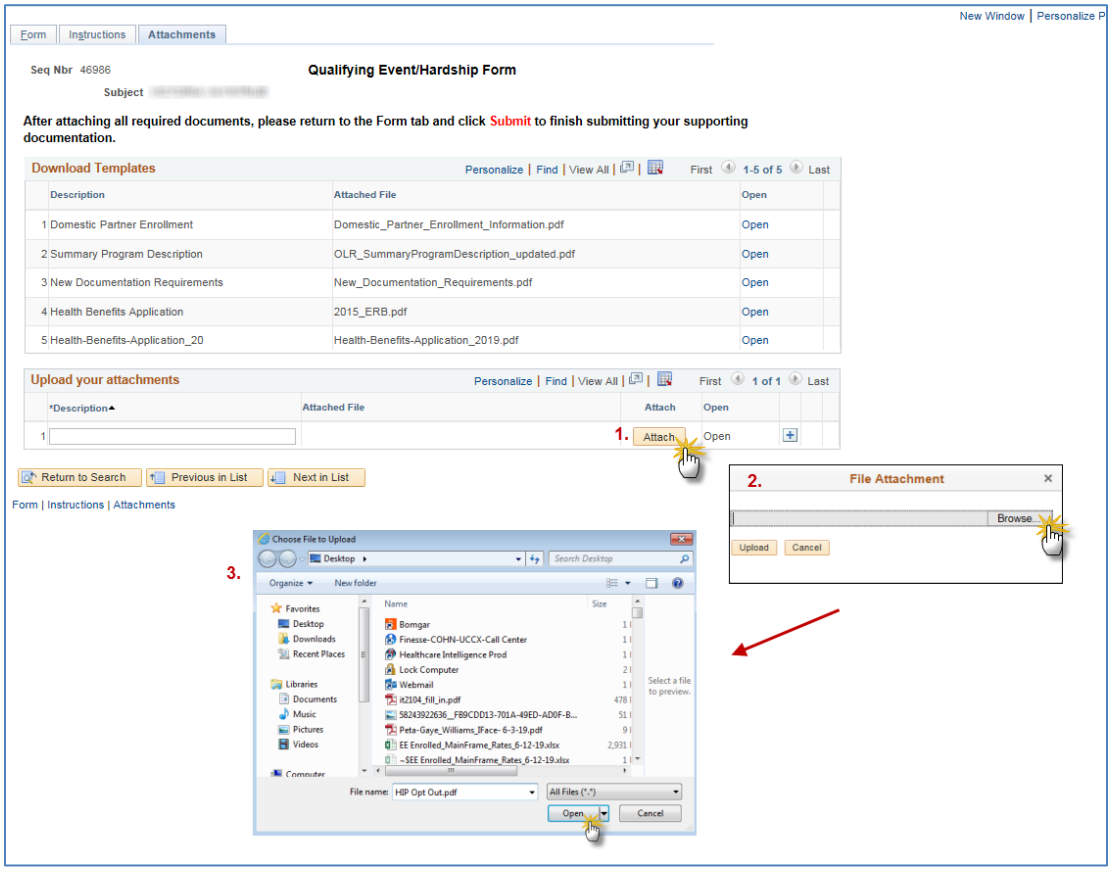


Complete the More Information text and continue by clicking on the **Save** button.

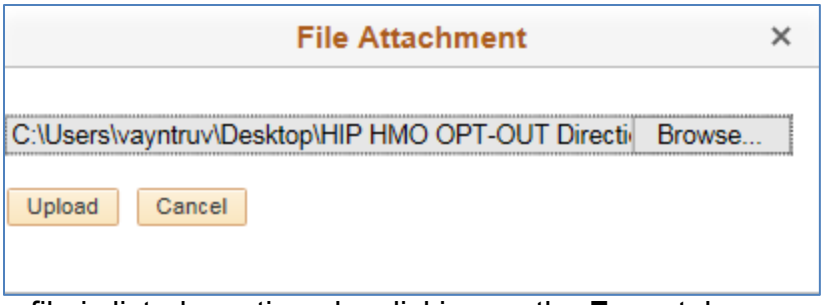


Once you click on save, you will see an **Attachment** tab that will populate, click on the **Attachment** tab.

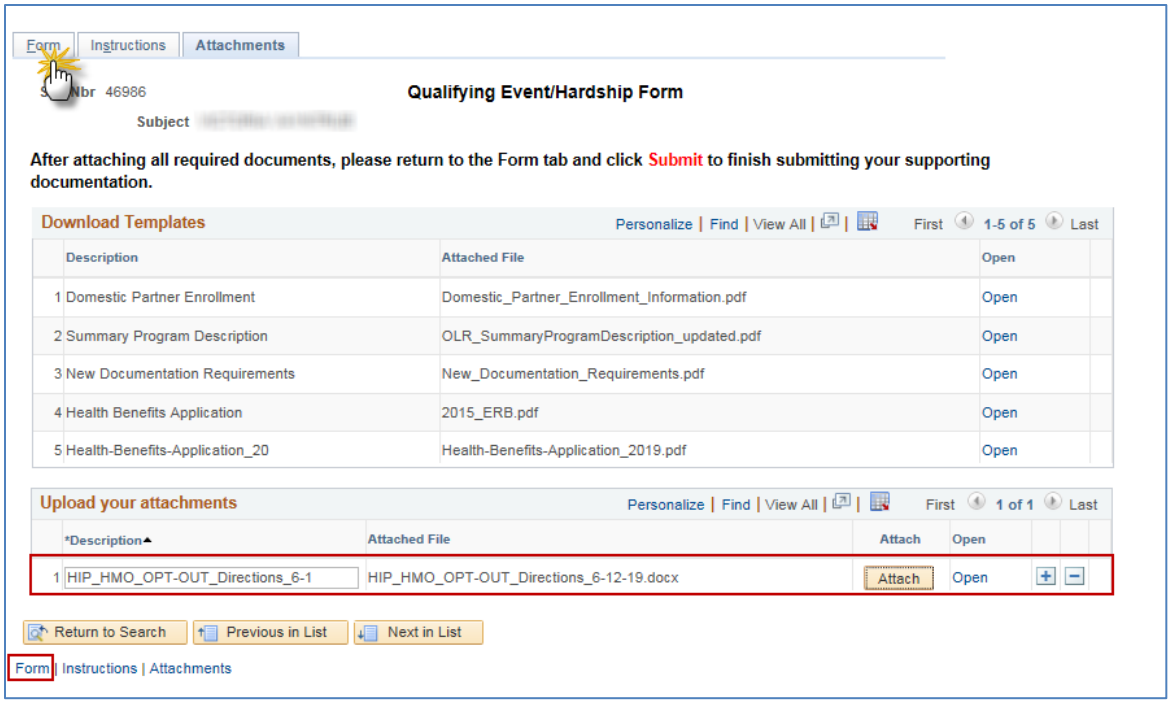
On the attachment Tab, click on the **Attach** button and then click on **Browse** button to search for your **Approved Opt-Out Form** and click **Open.**



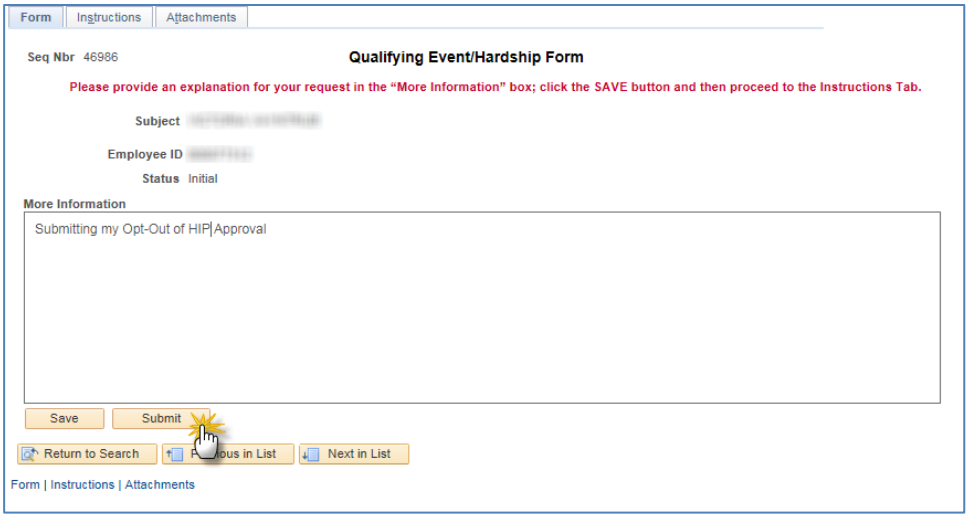
Once you have selected your file, continue by pressing the **Upload** button.



Confirm your file is listed, continue by clicking on the **Form** tab.



Click on the **Submit** button.



CITY OF NEW YORK

NEW EMPLOYEE HIP HMO OPT-OUT REQUEST FORM

Pursuant to the New York City Health Benefits Summary Program Description, all City of New York employees, and employees of Participating Employers, hired on or after October 1, 2022 will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan and must remain in the HIP HMO Preferred Plan for the first 365 days of employment.

An employee who needs to request an exemption to this requirement can do so by submitting this completed Opt-Out Request Form to EmblemHealth, via the email address provided below. An employee or eligible dependent must meet the criteria outlined below, and the request must be approved by EmblemHealth before the exemption is granted.

Criteria for Opt-Out (Check box below):

- ☐ If the new employee resides outside of the HIP HMO service area and cannot access primary care with one of the HMO providers. Visit https://www.emblemhealth.com/Members/City-of-New-York-Employees for a list of counties in HIP HMO Service Area. Please provide your name and address on the back of this form.

- ☐ If the new employee or eligible dependent is being treated by a non-network provider for a life-threatening or disabling disease or condition and is receiving ongoing treatment for a catastrophic or terminal illness or has a condition that requires complex case management (such as ventilator dependence or trauma). Please provide treating physicians name, address and phone number on the back of this form.

Process:

New employees need to complete and submit this New Employee HIP HMO Opt-Out Request Form immediately. *Please email completed* forms *to:* cityagencies@emblemhealth.com or fax *to 212-510-5919.*

Once your Opt-Out Request Form has been reviewed and a determination has been made, *you will be notified by EmblemHealth via the email* address *you have provided on the back of this* form. *If you* are *approved, you must submit the approval notification to NYCAPS* or *your agency benefits representative.*

Please complete the following:

Employee Information

Employee Last Name: _____ *Employee First* Name: _____

Date of *Birth:* _____ *Phone:* _____

Email Address: .....

Home Address: _____ *Home Zip:* ___ _

Agency: _____ *Date* of *Hire:* _____

Dependent Information:

(If the request for exemption is due to an eligible dependent, please also provide the following.]

Dependent's Last Name:_____ *Dependent's First* Name:_____

Dependent's Date of *Birth:* _____

Medical Information

Please check one:

- ☐ Self
- ☐ Dependent

Treating Physician's Name: _____

Physician's Phone: _____

Physician's Address: _____

Diagnosis/Condition: _____

EMPLOYEE/DEPENDENT'S SIGNATURE AND RELEASE ***(this form must be signed to be processed)***

I hereby request exemption from the above City Health Benefits Program requirement and certify that the above information is complete, true and correct. I authorize above listed physicians and other medical professionals to provide EmblemHealth with information concerning medical care, advice, treatment or supplies provided to the Employee or eligible dependent. I understand that this authorization will be used only for the purpose of obtaining information, and the duration of the authorization will be limited, to determine whether the employee or eligible dependent meets the criteria outlined above. I agree that a photostatic copy of this authorization is as valid as the original.

Employee Signature: _____ Date: _____

Dependent's Signature (if dependent is not a minor) _____ Date: _____

FOR OFFICIAL USE ONLY
• Approval
• Denial - does not meet criteria
Date:

Return to Directions