NYC HEALTH+ HOSPITALS

Opt-Out of MetroPlus GOLD Coverage
MetroPlus Health Plan Employees Only!

Pursuant to the NYC Health Benefits Summary Program Description established by the Office of Labor Relations, employees Of MetroPlus Health Plan that were hired on or after July 1, 2021 will only be eligible to enroll into the **MetroPlus GOLD** Plan.

If you or your eligible dependent are being treated by a non-network provider for a life threatening or disabling disease or condition or are receiving ongoing treatment for a catastrophic or terminal illness that requires complex management (such as ventilator dependence or trauma) you may have the ability to request to Opt-Out of the MetroPlus GOLD Coverage.

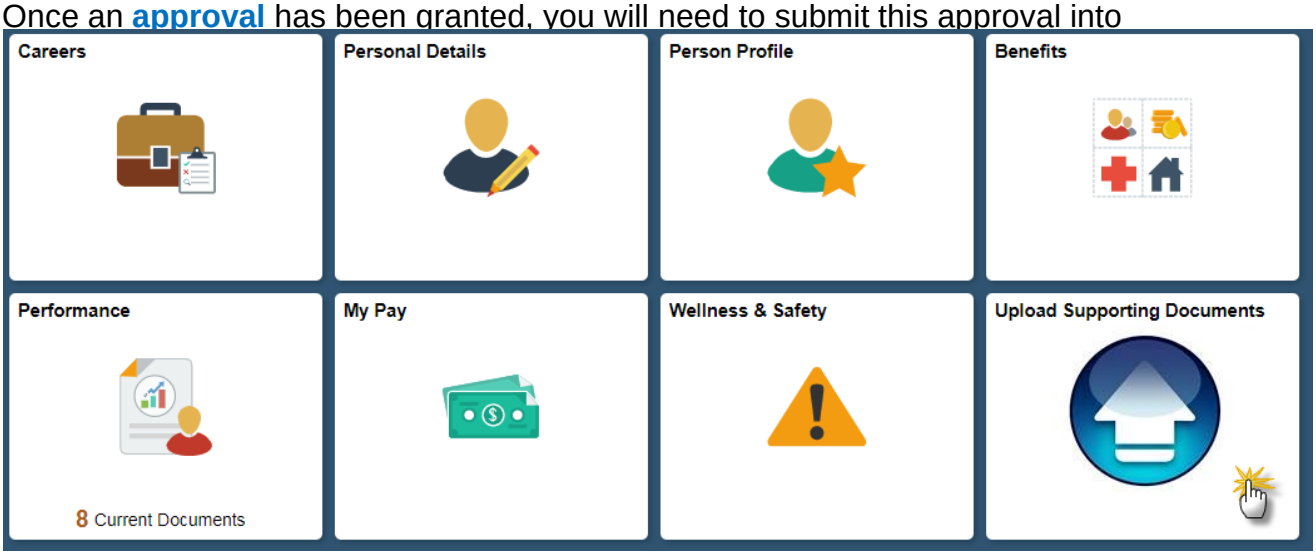
To request to Opt-Out of the MetroPlus GOLD Plan, you will need to complete an **Opt-Out Request Form.**

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

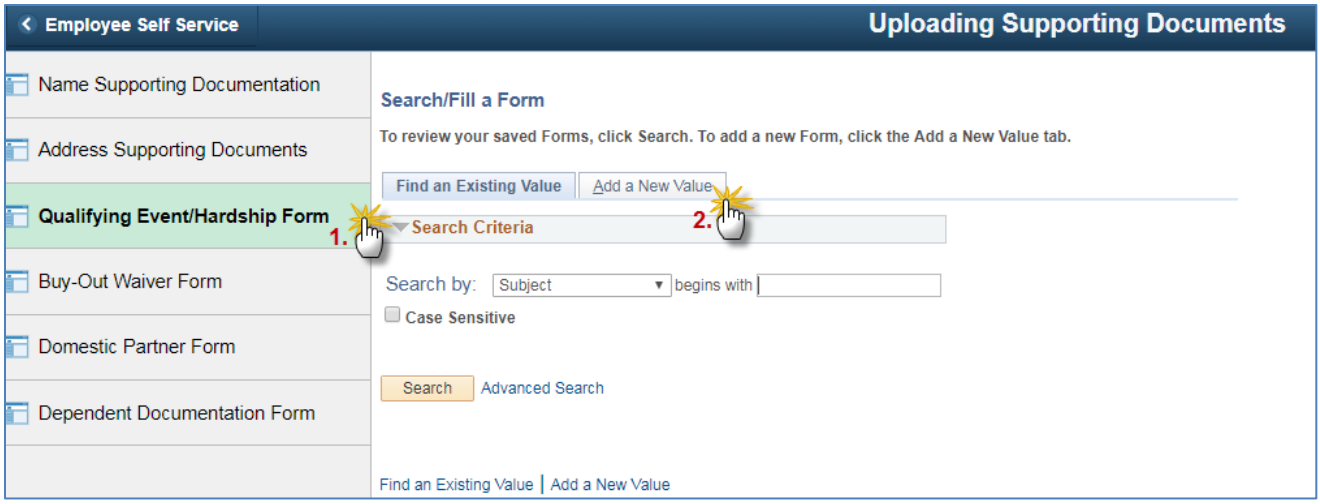
Email: mphr@metroplus.org

Fax: 212-908-5192

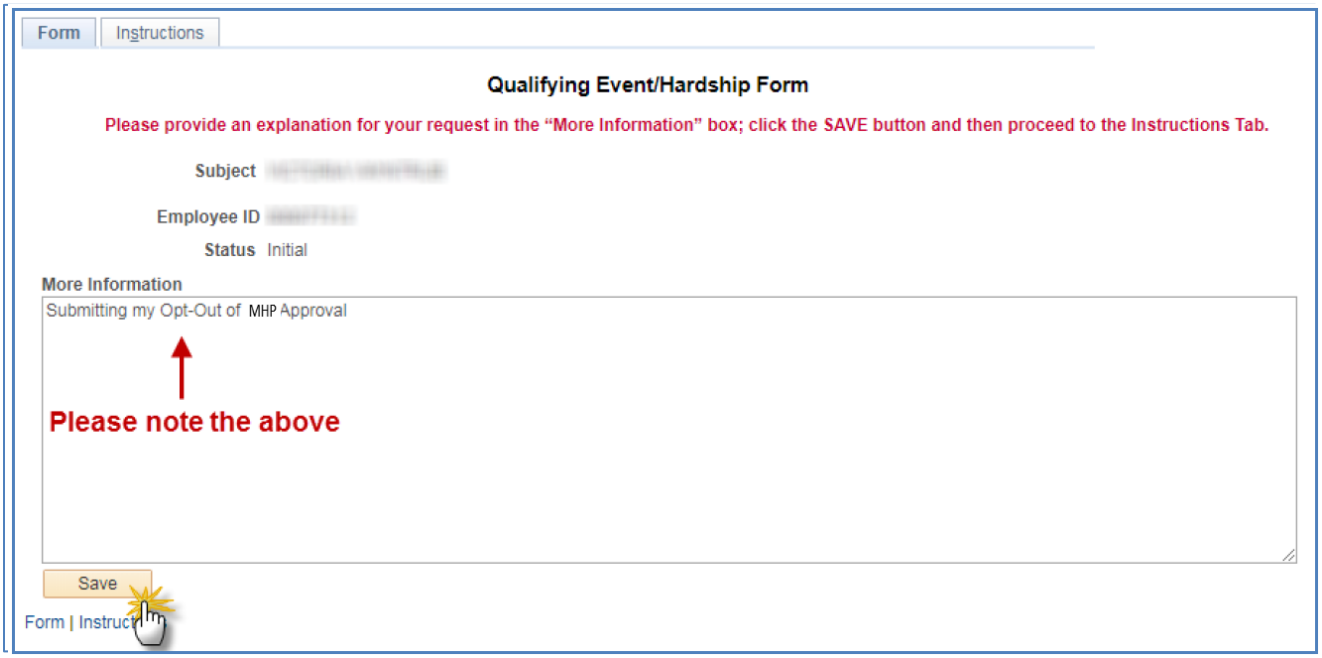
Once an **approval** has been granted, you will need to submit this approval into



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

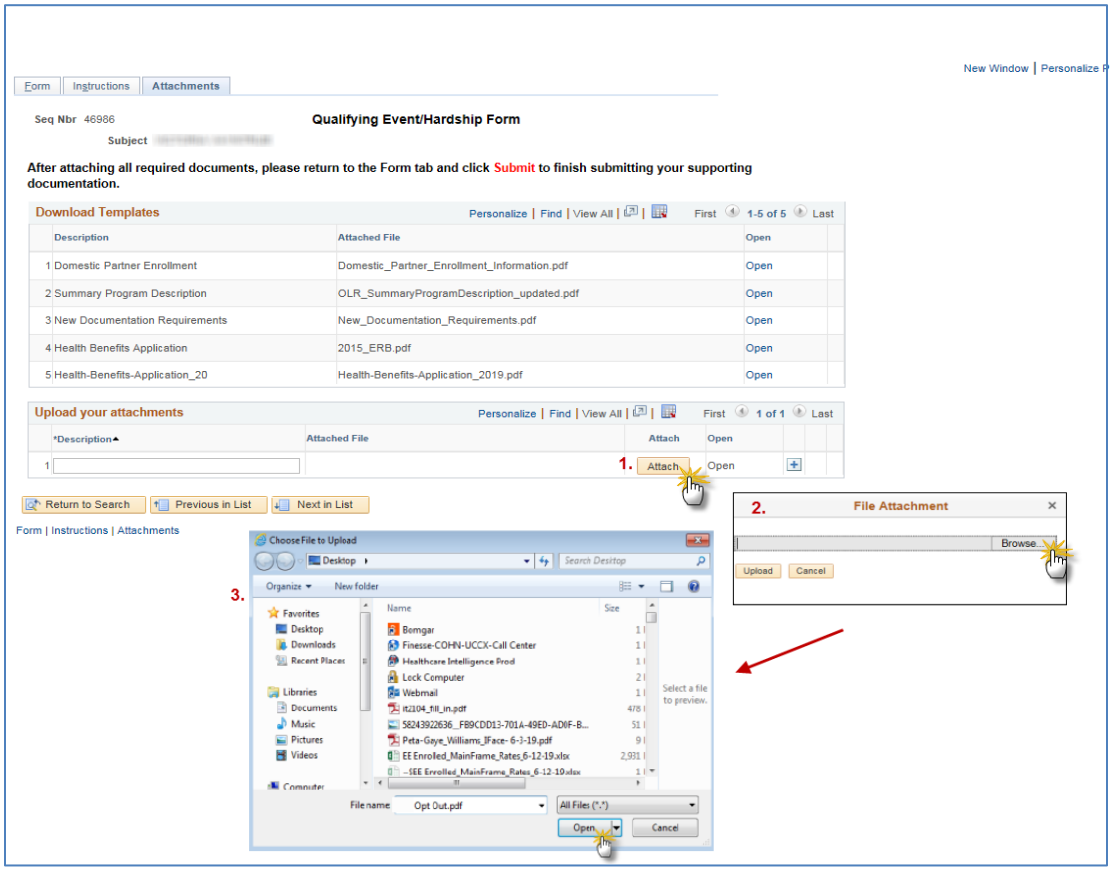


Complete the More Information text and continue by clicking on the **Save** button.

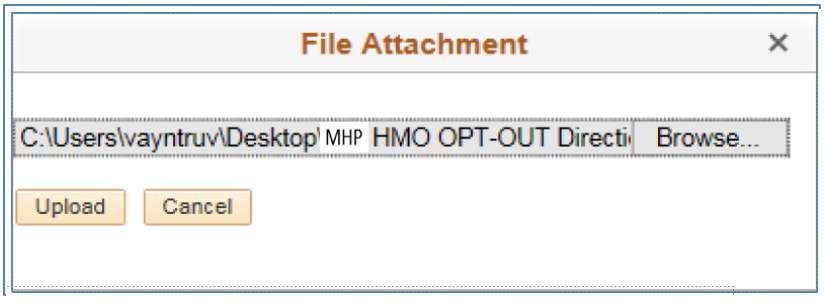


Once you click on save, you will see an **Attachment** tab that will populate, click on the **Attachment** tab.

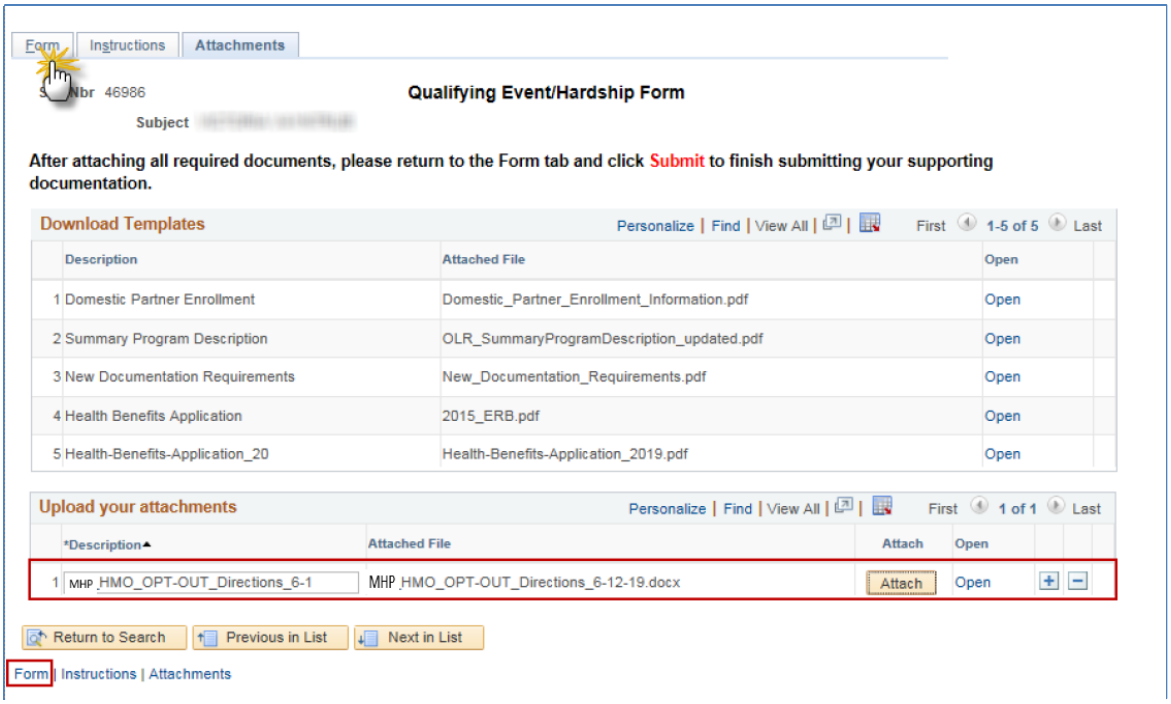
On the attachment Tab, click on the **Attach** button and then click on **Browse** button to search for your **Approved Opt-Out Form** and click **Open.**



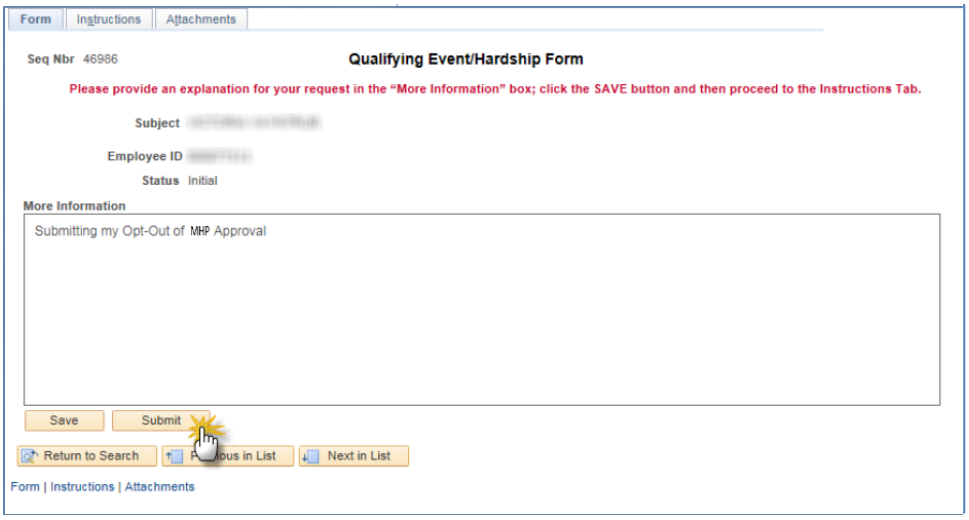
Once you have selected your file, continue by pressing the **Upload** button.



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



Click on the **Submit** button.



City of New York

New Employee MetroPlus GOLD Opt-Out Request Form

Pursuant to the New York City Health Benefits Summary Program Description, all Metroplus Health Plan employees hired on or after July 1, 2021 will only be eligible to enroll in the MetroPlus GOLD Preferred Plan and must remain in the MetroPlus GOLD 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 MetroPlus Health Plan, via the email address provided below. An employee or eligible dependent must meet the criteria outlined below, and the request must be approved by MetroPlus GOLD Preferred Plan before the exemption is granted.

Criteria for Opt-Out (Check box below):

☐ 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 MetroPlus GOLD Opt-Out Request Form immediately. Please email completed forms to:**mphr@metroplus.org** or fax to **212-908-5192.**

Once your Opt-Out Request Form has been reviewed and a determination has been made, you will be notified by MetroPlus Health Plan via the email address you have provided on the back of this form. If you are approved, you must submit the approval notification to your benefit representative. This form will be received and processed in accordance to all applicable federal and state laws and regulations on the guarding of personal health information (PHI).

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:	

(Continued)

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 MetroPlus GOLD Preferred Plan 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