

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:

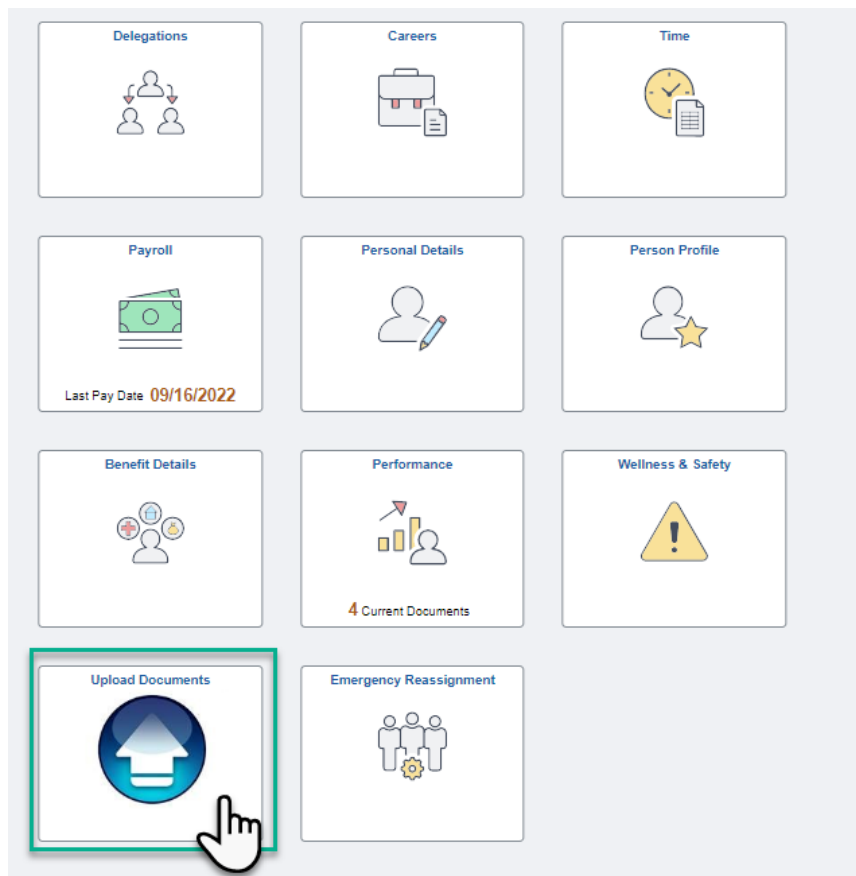
Email: cityagencies@emblemhealth.com

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**

Employee Self Service **Uploading Supporting Documents**

Search/Fill a Form
To review your saved Forms, click Search. To add a new Form, click the Add a New Value tab.

Find an Existing Value **Add a New Value**

Search Criteria

Search by: begins with

Case Sensitive

Search [Advanced Search](#)

[Find an Existing Value](#) | [Add a New Value](#)

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

Form | **Instructions**

Qualifying Event/Hardship Form

Please provide an explanation for your request in the "More Information" box; click the SAVE button and then proceed to the Instructions Tab.

Subject

Employee ID

Status Initial

More Information

Submitting my Opt-Out of HIP|Approval

Please note the above

Save

Form | Instru

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

Form | Instructions | **Attachments**

Seq Nbr 46986

Qualifying Event/Hardship Form

Please provide an explanation for your request in the "More Information" box; click the SAVE button and then proceed to the Instructions Tab.

Subject [REDACTED]

Employee ID [REDACTED]

Status Initial

More Information

Submitting my Opt-Out of HIP Approval

Save Submit

Return to Search Previous in List Next in List

Form | Instructions | **Attachments**

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**.

Form | Instructions | **Attachments**

Seq Nbr 46986

Qualifying Event/Hardship Form

Subject [REDACTED]

After attaching all required documents, please return to the Form tab and click **Submit** to finish submitting your supporting documentation.

Download Templates

| Description | Attached File | Open |
|----------------------------------|---|------|
| 1 Domestic Partner Enrollment | Domestic_Partner_Enrollment_Information.pdf | Open |
| 2 Summary Program Description | OLR_SummaryProgramDescription_updated.pdf | Open |
| 3 New Documentation Requirements | New_Documentation_Requirements.pdf | Open |
| 4 Health Benefits Application | 2015_ERB.pdf | Open |
| 5 Health-Benefits-Application_20 | Health-Benefits-Application_2019.pdf | Open |

Upload your attachments

| *Description* | Attached File | Attach | Open |
|---------------|---------------|-----------|------|
| 1 | | 1. Attach | Open |

Return to Search Previous in List Next in List

Form | Instructions | Attachments

File Attachment

Browse

Upload Cancel

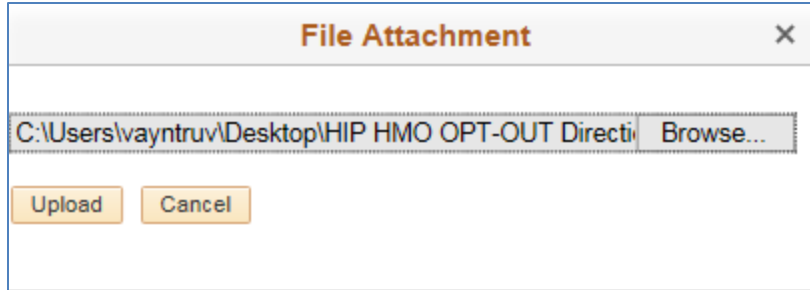
Choose File to Upload

File name: HIP Opt Out.pdf

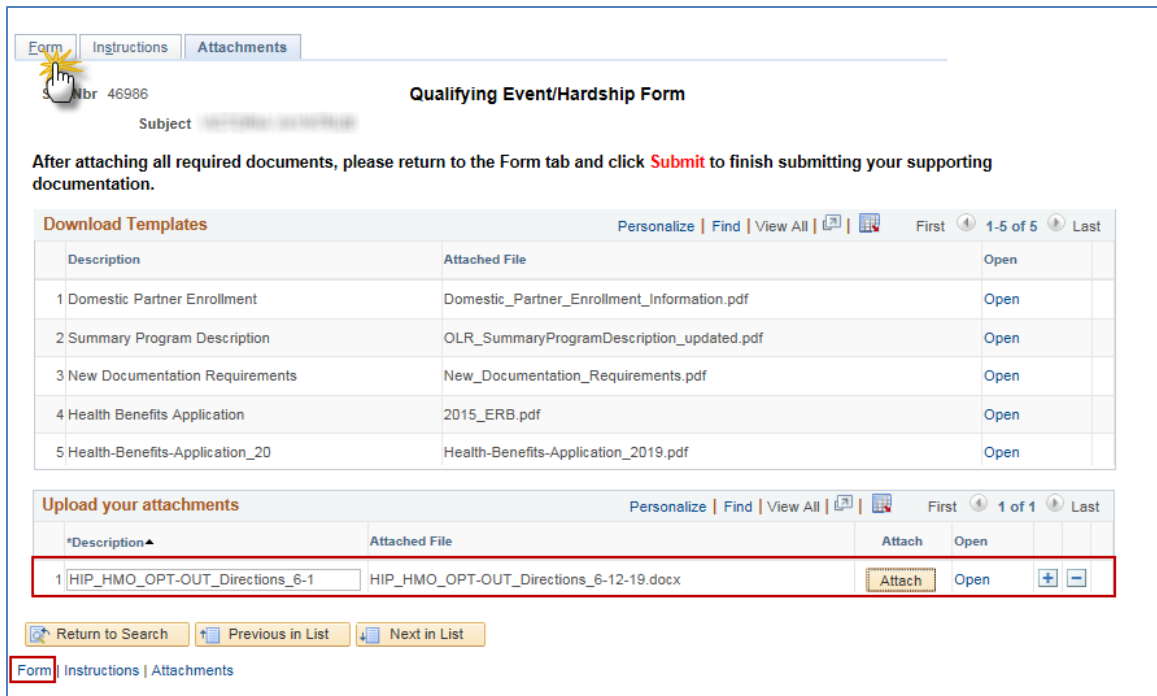
Open Cancel

3.

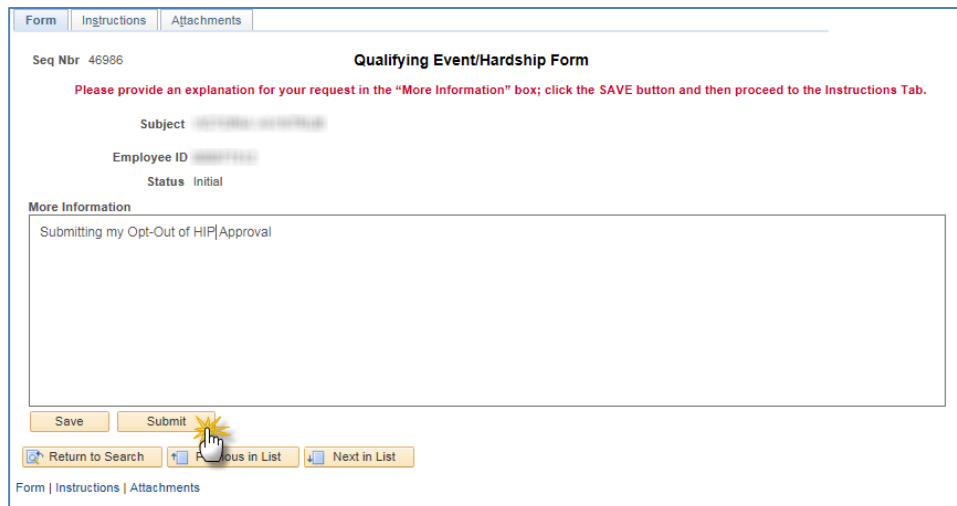
Once you have selected your file, continue by pressing the **Upload** button.



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 |
| <ul style="list-style-type: none">• Approval |
| <ul style="list-style-type: none">• Denial - does not meet criteria |
| Date: _____ |