

HUNTER

Human Resources

Memorandum

To: Hunter College Community

From: Valerie Kelly
Associate Director of Human Resources

Date: June 5, 2019

Re: **Health Plan Options for Newly Hired Employees on or after July 1, 2019**

All employees hired on or after July 1, 2019 will only be eligible to enroll in the EmblemHealth HIP HMP Preferred Plan and must remain in the HIP HMO Preferred plan for the first year (365 days) of employment.

After one year of employment (365 days), the employee will have the option of either remaining in the HIP HMP Preferred Plan or select a different health plan within 30 days before the end of the 365th day period. If the employee selects a new plan, the new plan will be effective on the 366th day.

Only after the 365th day of employment, the employee may participate in any Annual Fall Open Enrollment Period.

An employee who needs to request an exemption from the required enrollment in the HIP HMO Preferred Plan can do so by filing the New Employee HIP HMO Opt-Out Request Form if they meet the following criteria:

1. If the new employee resides outside of the HIP HMO Preferred, Plan area and cannot access a primary care physician that participates in the HIP HMO Preferred Plan. Please visit [https:// www.emblemhealth.com/Members/City-of-New-York-Employees](https://www.emblemhealth.com/Members/City-of-New-York-Employees) for a list of counties in the HIP HMO Preferred Plan service area. Please provide your name and address on the back of the form.
2. If the new employee or eligible family member 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 the treating physician's name, address and phone number on the back of the form.

Please email the HIP HMO Preferred Plan Opt-Out Request form to: cityagencies@emblemhealth.com or fax to 212 510-5445. You may also mail the form to: EmblemHealth, Attn: Opt-Out form Processing Center, 55 Water Street, New York, NY 10041.

If you receive an approval to opt out of the plan, you will be notified via email. Once you receive notification, please bring it to the Benefits Office immediately.

For your convenience, I attached the HIP HMO Preferred Plan Opt-Out form for your review. If you should have additional questions, please feel free to contact the Benefits Office.

/vk

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: _____

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 July 1, 2019 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 212-510-5445. You can also mail the completed form to: EmblemHealth Attn: Opt-Out Form Processing Department, 55 Water Street New York, NY 10041.

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.