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GOVERNOR

STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
ALFRED E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12239
www.cs.ny.gov

NY 11-46r2

TO: New York State Agency Employee Health Benefit Administrators
FROM: Employee Benefits Division (EBD)
SUBJECT: Health Insurance Opt-Out Program
DATE: December 2, 2011

Effective January 1, 2012, the New York State Health Insurance Program (NYSHIP) will offer the Opt-Out Program. This program allows eligible employees, who have other employer-sponsored group health insurance, to opt out of their NYSHIP coverage in exchange for an incentive payment. This program is available to Executive branch employees represented by CSEA and PEF, unrepresented Executive branch employees, employees of the Legislature, and employees of the Unified Court System. On an annual basis, employees who elect to participate in the Opt-Out Program will receive incentive payments totaling $1,000 for opting out of Individual coverage or $3,000 for opting out of Family coverage.

Note: Other employer sponsored group health insurance 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.

Eligibility

To be eligible for the Opt-Out Program, an employee must meet two eligibility criteria to receive the incentive payment:

1. The employee must have been enrolled in NYSHIP, as a State employee, on April 1, 2011 or on the date **first** eligible for NYSHIP if that date is after April 1, 2011 through the end of the plan year; and

2. The employee must provide information and attest to having other employer sponsored group health insurance in effect for the Opt-Out period.

Opting Out for Employees Currently Enrolled in NYSHIP

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 a **PS-409 - Opt-Out Attestation Form** and a **PS-404 - NYS Health Insurance Transaction Form** for each year of participation. The actual effective date of the opt-out (i.e., the date NYSHIP coverage will no longer be in effect) depends upon the employee's payroll cycle; please refer to the annual option transfer memos for dates. Refer to HBA Memo NY 11-43 for the 2012 Benefit Plan effective dates.

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 their eligibility for NYSHIP benefits. 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 a PS 409 Opt-Out Attestation Form and PS 404 NYS Health Insurance Transaction Form.

Incentive Payments

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 pay 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 rounded up) or $115.39 for opting out of Family coverage ($3,000/26 paychecks rounded up).

Incentive payments to employees participating in the Opt-Out Program for 2012 will begin as soon as practicable after January 1 when necessary program changes are in place. After 2012, the annual Opt-Out Program incentive payments will begin coincident with the plan year's rate change, as described in the Annual Option Transfer Memo.

NYBEAS Processing

In order to process the employee's election for the Opt-Out Program, HBAs must process a Benefit Plan Change transaction.

For employees who are currently enrolled in NYSHIP:

Transaction Type During Option Transfer	**Date of Request = Signature Date on PS-404**	**Plan Type**	**Benefit Plan**	**Transaction Effective Date**
Benefit Plan Change Action Reason (PLN/CHG)	Enrollees will have 30 days from the date rates are approved to submit a PLN/CHG to enroll in the Opt-Out Program.	10 (Medical)	700 (Opt-Out)	For Administration: January 5, 2012 For Institution: December 29, 2011

For employees who are newly eligible to participate in the Opt-Out Program due to a change in Bargaining Unit:

Transaction Type Outside Option Transfer	**Date of Request = Signature Date on PS-404**	**Plan Type**	**Benefit Plan**	**Transaction Effective Date**
Benefit Plan Change Action Reason (PLN/SPC)	Enrollees will have 30 days from the date newly eligible to submit a PLN/SPC in the Opt-Out Program.	10 (Medical)	700 (Opt-Out)	Date of request

For employees who are newly hired or newly eligible for benefits and are eligible to participate in the Opt-Out Program:

Transaction Type Enrolling a New Hire	**Date of Request = Signature Date on PS-404**	**Plan Type**	**Benefit Plan**	**Transaction Effective Date**
Enrollment Action Reason (ENR/REG)	Enrollees will have 30 days from the date newly eligible to submit a ENR/REG in the Opt-Out Program.	10 (Medical)	700 (Opt-Out)	After appropriate waiting period (42 days for CSEA and 56 days for M/C & PEF)

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 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 PS-404 and provide proof of the qualifying event within 30 days 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, please contact your EBD processor.

Enclosures
FAQ's
PS 409 Attestation Form

Frequently Asked Questions

Q. What is considered other employer-sponsored group health insurance coverage for the purpose of qualifying for the Opt-Out Program?
A. To qualify for the Program you must be covered under an employer-sponsored group health insurance plan through other employment of your own or a plan that your spouse, domestic partner or parent has as the result of his or her employment. The other coverage cannot be NYSHIP coverage provided through employment with the State of New York. However, NYSHIP coverage through another employer such as a municipality, school district or public benefit corporation qualifies as other coverage.

Q. Will I qualify for Opt-Out Program incentive payments if I change from Family to Individual coverage?
A. No. If you are enrolled for NYSHIP coverage you will not qualify for the incentive payment.

Q. If I elect the Opt-Out Program for 2012, will I automatically be enrolled in the Program for the following plan year?
A. No. Unlike other NYSHIP options, you must elect the Opt-Out Program on an annual basis. If you do not make an election for the next plan year, your enrollment in the Opt-Out Program will end and the incentive payment credited to your paycheck check will stop.

Q. If I opt out and I find that I don't like my alternate coverage (for instance, my doctor does not participate) can I withdraw my enrollment in the Opt-Out Program and reenroll in NYSHIP coverage?
A. No. This is not a qualifying event. During the year you can terminate your enrollment in the Opt-Out Program and reenroll in NYSHIP benefits only if you experience a qualifying event (according to federal Internal Revenue Service (IRS) rules), such as a change in family status or loss of other coverage.

Q. If my spouse's (domestic partner's or parent's) employer has its open enrollment period (or option transfer period) at a different time of the year, how can I coordinate the effective date of my other coverage with the start of the Opt-Out Program?
A. Under IRS rules, if an employee's spouse drops coverage under his or her employer plan during Option Transfer, the employee can be permitted to enroll the spouse mid-year in his or her employer plan as long as the plans have different open enrollment periods. **You should check to see whether your spouse's employer will permit your spouse to enroll you as a dependent.** You are responsible for making sure your other coverage is in effect.

Q. What if I lose my other coverage and do not request enrollment for NYSHIP benefits with The Empire Plan or a NYSHIP HMO within 30 days of losing that coverage?
A. If you fail to make a timely request, you will be subject to NYSHIP's late enrollment waiting period, which is five biweekly pay periods. You will not be eligible for NYSHIP coverage during the waiting period.

Q. Can I get a lump sum payment if I elect the Opt-Out Program?
A. No. The Opt-Out Program incentive payment is prorated and reimbursed through your biweekly paycheck throughout the year.

Q. If I am eligible for health, dental and vision coverage as a State employee, do I have to opt out of all three benefits to receive the incentive payment?
A. No. The Opt-Out Program incentive payment applies to health insurance coverage only. If you enroll in the Program, your eligibility for dental and vision coverage will not be affected.

Q. When I enroll in the Opt-Out Program, what information will I need to provide about the other employer-sponsored group health coverage I will be covered by?
A. To enroll you must complete a PS-409. You will be required to attest that you are covered by other employer-sponsored group health coverage and provide information regarding the person that carries that coverage, as well as the name of the other employer and other health plan.

Q. I had Individual NYSHIP coverage prior to April 1, 2011, and changed to Family coverage when I got married in July. Will I qualify for the $3,000 family incentive payment even though I did not have Family coverage as of April 1?
A. Employees who enrolled in Family coverage due to a qualifying event and did so on a timely basis between April 1, 2011 and the end of 2011 are eligible for the higher incentive payment. You will not be eligible for the higher incentive payment if you enrolled for Family coverage after April 1 and were subject to a late enrollment waiting period.

Q. Will participating in the Opt-Out Program affect my eligibility for NYSHIP coverage in retirement?
A. No. Participation in the Opt-Out Program satisfies the requirement of enrollment in NYSHIP at the time of your retirement.

State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
2012 OPT OUT ATTESTATION FORM
PS 409 12/11

INSTRUCTIONS: *READ THE OPT- OUT PROGRAM INFORMATION ON THE FOLLOWING PAGE AND COMPLETE THE INFORMATION ON THIS PAGE. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.*

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 ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	9. Marital Status Date	

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 health insurance coverage, (Other than the State of New York) to be eligible for the Opt-out Program.

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).

Alternate 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_____

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 an alternate employer sponsored health plan and have provided alternate plan information.
- I understand that I must promptly report changes to my status (employment or family) which may change my eligibility during the plan year.
- I understand that during the next annual option transfer period, I must re-elect to opt out or enroll in a NYSHIP benefit option to avoid a NYSHIP late enrollment and experience a gap in coverage.
- 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 2012 only.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

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

Employees who can demonstrate and attest to having other employer-sponsored group health insurance may elect to opt out of NYSHIP's Empire Plan or Health Maintenance Organizations. Employees who elect to opt out of NYSHIP will receive $1,000 for waiving Individual coverage or $3,000 for waiving Family coverage. This amount will be credited to bi-weekly paycheck s as taxable income over the plan year. Unless newly eligible to enroll, employees must be enrolled in NYSHIP Individual or Family coverage prior to April 1st of the previous plan year to be eligible to opt out of that coverage. In order to participate, employees must have other employer-sponsored group health insurance.

There are two times a year when employees may elect to opt out of coverage; as newly eligible for health benefits, and, for currently enrolled employees, during the option transfer period. Only employees who experience a qualifying event will be allowed to withdraw their opt out election and enroll in a health insurance plan mid-year. See instructions below.

INSTRUCTIONS:

Newly eligible employees: Employees may enroll in the Opt-out Program no later than their first date of NYSHIP eligibility. Employees must sign the Opt-out Attestation Form and complete a PS404 Enrollment Form.

Current enrollees: Eligible enrollees may elect the Opt-out Program during the annual Option Transfer Period for an effective date of January 1, 2012. Employees must sign the Opt-out Attestation Form and complete a PS404 Enrollment Form.

During mid-year: Employees who experience a Qualifying Event (QE) must notify their personnel office within thirty (30) days of the QE date in order to enroll in a health insurance plan without a waiting period. Employees must complete a PS404 Enrollment Form.

By signing the Opt-out Attestation, you elect to receive $3,000 (Family coverage waived), or $1,000 (Individual coverage waived); this amount will be credited to your bi-weekly paycheck as taxable income over the plan year.

The information you provide on this application is requested in accordance with Section 163 of 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, and 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

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This form is not valid if it is not signed and submitted along with a completed PS 404.

State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 (12/11)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name First Name MI	**2.** Social Security Number	**3.** Sex ☐ Male ☐ Female
4. Street Address City State Zip		
5. Date of Birth	**6.** Telephone Numbers Home ( ) Work ( )	**7.** Work location and address
8. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Marital Status Date	
9. Covered under Medicare? Self ☐Yes ☐ No Spouse/Domestic Partner ☐Yes ☐ No Child ☐Yes ☐ No		

10. ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	Medical *(10)* *(Select Empire Plan, HMO or opt out)* ☐Empire Plan ☐ HMO Code ☐ Name _____ ☐OPT OUT If choosing opt out, you must also complete the PS409 Opt-out Attestation Form	☐ Dental *(11)*	☐ Vision *(14)*
B. ☐ Request Enrollment- **Family** (Complete G)	Medical *(10)* *(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO Code ☐ Name _____ ☐ OPT OUT If choosing opt out, you must also complete the PS409 Opt-out Attestation Form	☐ Dental *(11)*	☐ Vision *(14)*
C. ☐ Elect Pre-Tax Status for Premium deduction?	D. ☐ Elect Post-Tax Status for Premium deduction?	Initial here to indicate that you have read the Pre-Tax Contribution memorandum. _____	
E. ☐ Decline Coverage	☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* *(Process WAV/BEN transaction)*		
F. ☐ Voluntarily Cancel Coverage	☐Medical *(10)* Qualifying Event:	☐ Dental *(11)*	☐ Vision *(14)*

G. ☐ Change Coverage ☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **Date of Event: _____**

☐ **Change to FAMILY** *(Complete G)*
- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated *(Complete Section 11)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**
- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-425.4)*
- ☐ Other _____

DEPENDENT INFORMATION

Must be provided when choosing to enroll or opt-out of NYSHIP coverage ***(use additional sheets if necessary)***

Check One: A (Add), D (Delete) or C (Change)
Check all that apply: M (Medical), D (Dental), and V (Vision)
Date of Event _____

	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C ☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C ☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C ☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C ☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C ☐ M ☐ D ☐ V						

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

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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 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 1st Eligibility (PE only)	Percentage Working	Agency Code	Neg. Unit	Ret. System

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature: **Date:**