

**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.

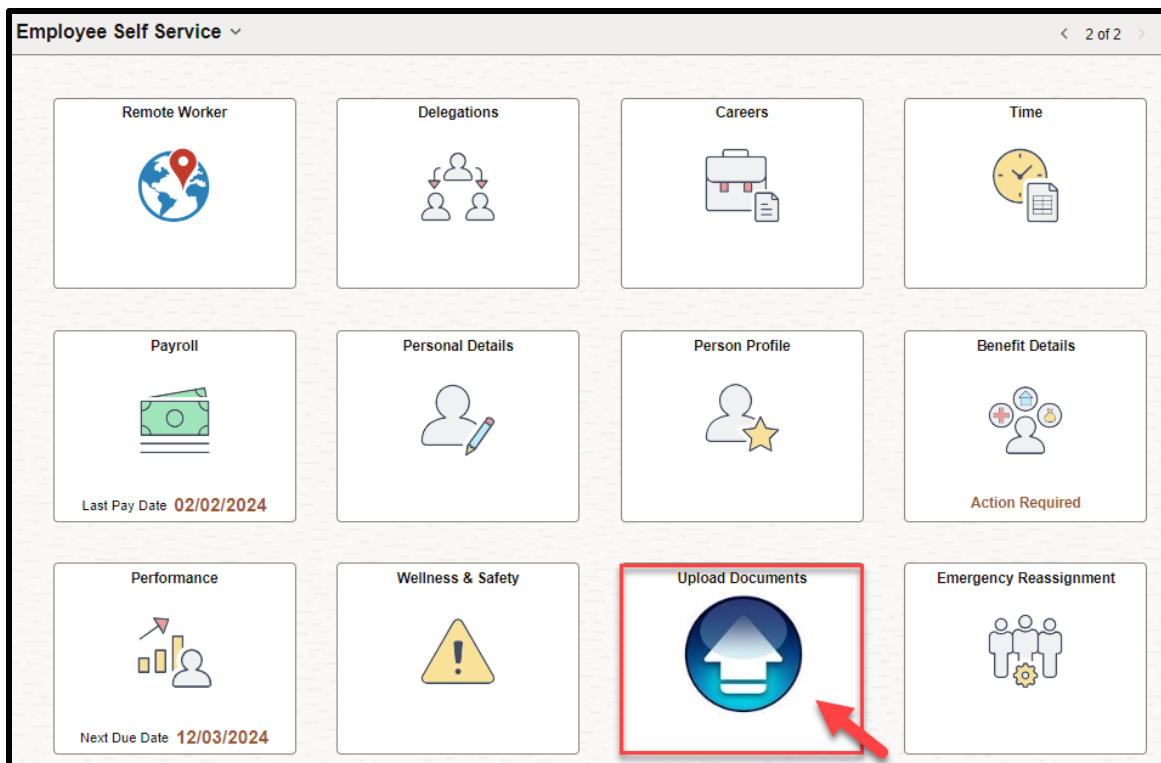
To request to Opt-Out of the MetroPlus GOLD Plan, you will need to complete an [Opt-Out Request Form](#).

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

**Email:** [mphr@metroplus.org](mailto:mphr@metroplus.org)

**Fax:** 212-908-5192

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









## **Submitting Qualifying Event/Hardship Form**

2. Select the appropriate form for your event. *(Be sure your selection is highlighted)* **Qualifying Event/ Hardship Form**

The following documents are needed for adding dependents:

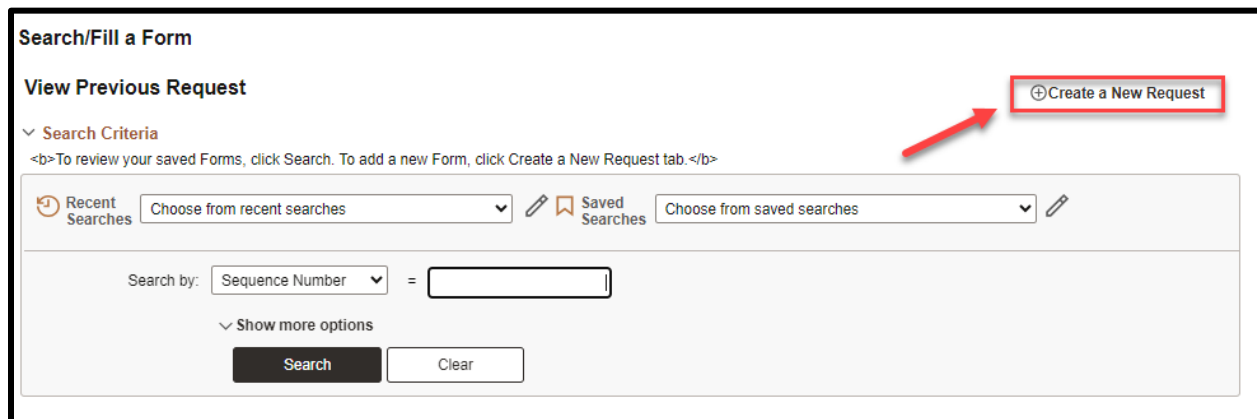
- Dependent(s) Birth certificate
- Marriage certificate
- Proof of cohabitation if married over a year. *(Example: utility bill, current bank statement, mortgage statement, tax return for current year or current lease, this to prove you and your spouse reside in the same household.)*

For divorce please submit the court documents the divorce creed.  
Upload clear photos or scanned copies, ensuring they meet file format and size requirements.

Upload Documents	
	Name Supporting Documentation
	Address Change Form
	<b>Qualifying Event/Hardship Form</b>
	Buy_Out_Waiver
	Domestic Partner Form
	Dependent Documentation Form

## Submitting Qualifying Event/Hardship Form

3. Select the **Create a New Request** tab to create a new form.



The screenshot shows a web interface titled "Search/Fill a Form". At the top left, there is a link "View Previous Request". Below this is a section "Search Criteria" with a dropdown arrow. A text instruction reads: "<b>To review your saved Forms, click Search. To add a new Form, click Create a New Request tab.</b>". Below the instruction are two search filters: "Recent Searches" with a dropdown "Choose from recent searches" and "Saved Searches" with a dropdown "Choose from saved searches". Below these is a search bar with "Search by:" followed by a dropdown "Sequence Number", an equals sign, and an empty input field. Below the search bar is a link "Show more options". At the bottom are two buttons: "Search" and "Clear". In the top right corner, there is a button "Create a New Request" which is highlighted with a red box and a red arrow points to it from the left.

## Submitting Qualifying Event/Hardship Form

4. This will take you to the **Form** tab.

- Answer the questions posed on the form and provide an explanation for your request. If the request is outside of your event time frame explain the cause of your delay.
- Click the *Save* button, then proceed to the Instructions tab.

**Form**   Instructions   Attachments

Seq Nbr 132351   **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

\*Do you currently have health coverage through HHC? Yes

\*What is the effective date of your qualifying event? 03/19/2024

More Information

Form | [Instructions](#) | [Attachments](#)

## Submitting Qualifying Event/Hardship Form

5. The **Instructions** tab will explain which supporting documents are acceptable, where to attach and how to submit your request.

Form
**Instructions**
Attachments

### Qualifying Event/Hardship Form

Please use this form to request changes to your health coverage for events such as Loss of Coverage, Divorce, Domestic Partner Changes, or other Qualifying Hardship events.

1. Complete and attach a **Health Benefits Application** on the Attachments tab. Please include all dependents that you wish to cover, not only new additions. This form can be viewed in a new window when clicking the **Open** link and then printed.
2. If adding dependents for the first time, supporting documentation for these dependents should also be submitted.
3. Appropriate documentation of marital status or dependent child relationship is required. This documentation may consist of:
  - Marriage or Birth Certificate
  - Adoption or Guardianship papers
  - Copies of Tax Returns indicating a step-child is claimed as a dependent
  - For a complete list of required documentation, please go to the Attachments tab and click the **Open** link for the **New Documentation Requirements**.
4. If your qualifying event is a Divorce, please attach a copy of the Divorce Decree. If your qualifying event is a Domestic Partner Change, please review the document "Domestic Partner Enrollment" located on the Attachments tab.
5. If adding a dependent who was dropped during the Dependent Eligibility Verification Audit, please submit the equivalent supporting documentation that was required during the audit, this could include:
  - Federal Tax Return within the last two years listing your spouse (Please only send the first page of your Federal Tax Return and block out all Social Security numbers and monetary amounts)
  - Proof of Joint Ownership issued within the last six months
6. Please provide the appropriate documentation, click the **Attach** button to submit a scanned copy on the Attachments tab.
7. **After attaching all required documents on the Attachments tab, return to the Form tab and click **Submit**.**

For instructions on how to scan and upload documentation, please read the How to guide on the ESS website: <http://ess.nychhc.org>

Form
**Instructions**
Attachments

## Submitting Qualifying Event/Hardship Form

6. After you have read the instructions, select the **Attachments** tab.

Click the **Open** links to view and/or print the different blank forms. Complete these form(s) with the appropriate information, if applicable.

Form Instructions **Attachments**

Seq Nbr 132348 Buy\_Out\_Waiver

Subject [REDACTED]

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

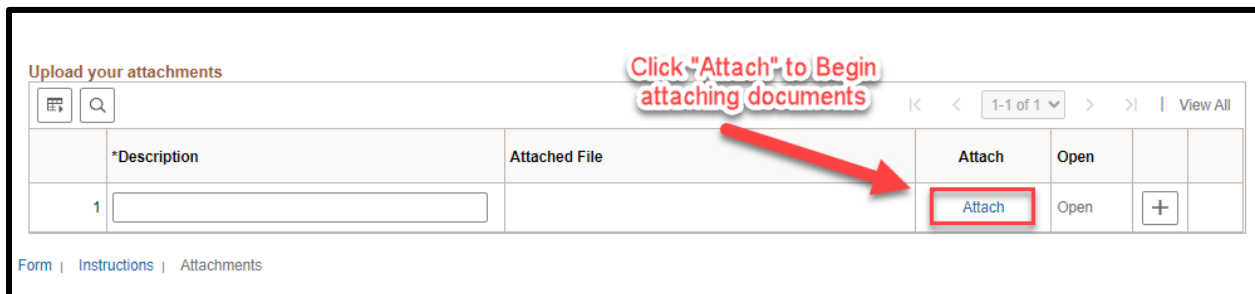
**Download Templates**

View and/or prints forms

	Description	Attached File	Open
1	Dependent Verification	Dependent_Verification.pdf	<b>Open</b>
2	Summary Program Description	SPF_Updated.pdf	Open
3	Health Benefits Application	health-benefits-application_Signature.pdf	Open
4	Buy-Out Waiver Form	mssc-buyout-waiver-form.pdf	Open

## Submitting Qualifying Event/Hardship Form

7. Then scan any supporting documents and attach the electronic documents by clicking the **Attach** button.



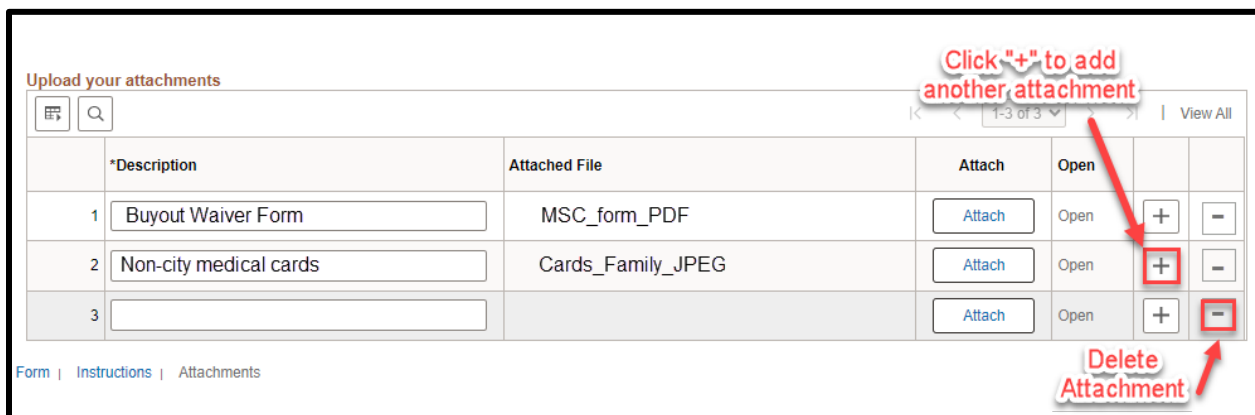
Upload your attachments

Click "Attach" to Begin attaching documents

	*Description	Attached File	Attach	Open		
1	<input type="text"/>		Attach	Open	+	

Form | Instructions | Attachments

8. You can add additional attachments by selecting the + button and delete them by selecting the - button.



Upload your attachments

Click "+" to add another attachment

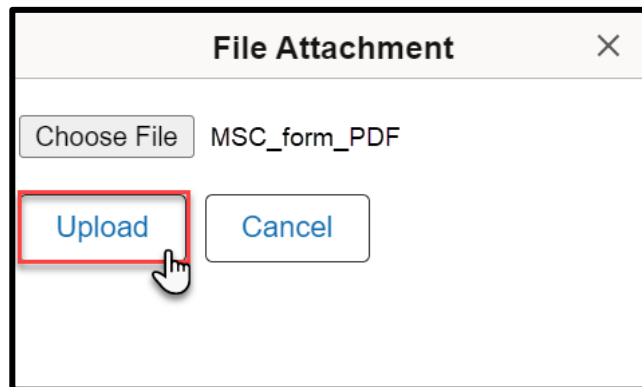
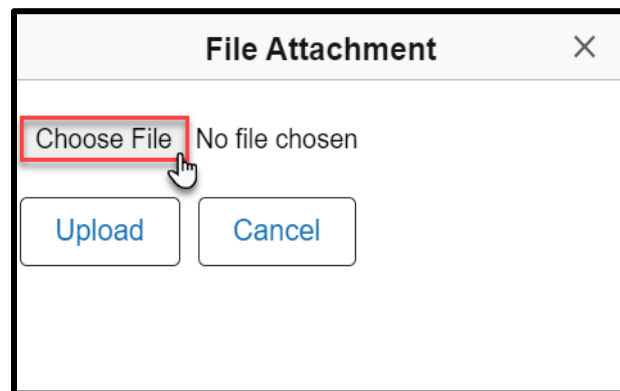
	*Description	Attached File	Attach	Open		
1	Buyout Waiver Form	MSC_form_PDF	Attach	Open	+	-
2	Non-city medical cards	Cards_Family_JPEG	Attach	Open	+	-
3	<input type="text"/>		Attach	Open	+	-

Form | Instructions | Attachments

Delete Attachment

## Submitting Qualifying Event/Hardship Form

9. The File Attachment pop up appears. Click the ***Choose File...*** button to search for your document. After finding your document, click the ***Upload*** pushbutton to upload your document.





## Submitting Qualifying Event/Hardship Form

- 10.** After you have attached all files, go back to the **Form** tab. Click the Submit button at the bottom for your Form to be sent to HRSS Corporate Benefits for review.

**Form** | Instructions | Attachments

Seq Nbr 132339 **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

\*Do you currently have health coverage through HHC? Yes

\*What is the effective date of your qualifying event? 02/29/2024

**More Information**

I would like to enroll in coverage due to loss of my Medicaid coverage effective date 1/1/2024. Please see attached documents.

Save Submit

**Form** | Instructions | Attachments

## Submitting Qualifying Event/Hardship Form

11. The following screen will appear that shows the status as Pending. Click the **OK** button at the bottom.

The screenshot displays a web interface for submitting a Qualifying Event/Hardship Form. At the top, the title "Qualifying Event/Hardship Form" is centered. Below it, a "Subject" field is visible. The main section is titled "Review/Edit Approvers" and contains a list of items. The first item, "Qualifying Event/Hardship Form: 132339:Pending", is highlighted in blue and includes a "View/Hide Comments" link. Below this, a "Skipped" section shows a "eBenefits Approvals" entry dated "02/29/24 - 4:08 PM". A "Pending" section shows a "Multiple Approvers" entry dated "eBenefits Approvals". A "Comments" section is also visible. At the bottom left, an "OK" button is highlighted with a red rectangle and a mouse cursor icon.

If you have any questions about your elections you can contact HRSS/NYC Heath + Hospitals Corporate Benefits by phone at (646) 458-5634 or by email at [HHCBenefits@nychhc.org](mailto:HHCBenefits@nychhc.org).

# 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](mailto: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: