
PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

106 Washington Avenue, Plainview, New York 11803



Office of Business and Finance

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*Richard Cunningham
Assistant Superintendent for Business*

September 3, 2021

TO: All Employees Eligible for Health Insurance Buyout

FROM: Richard Cunningham
Assistant Superintendent for Business

RE: HEALTH INSURANCE COVERAGE – BUYOUT 2021-2022 School Year

Among the provisions of the collective bargaining agreements (CBA) between the District and certain units is the right of a staff member eligible for health insurance to receive a buyout for such coverage if they elect not to take the coverage. In essence, a staff member may drop his/her medical coverage and be reimbursed a *portion* of the premium saved from the District's contribution. Please refer to the "Health Insurance" section of your CBA for the specific language related to this provision.

Please note the following as to those eligible for the buyout:

- ***Even if you have elected to receive the buyout in the past, you must fill out the form on back and return to Carol Portugal no later than October 1st.***
- Payment to the unit member as referred to herein shall be made in two installments:
 - 1) the second pay period of January 2022 and;
 - 2) the first pay period of June 2022
- The unit member must notify the District no later than October 1st of each year of his/her decision to drop insurance coverage.
- When returning this form you must provide proof of coverage (a copy of your insurance card).
- You should be aware that the health provision has restriction to changes in coverage. You can find information on the plans the District offers at:
NYSHIP <https://www.cs.ny.gov/employee-benefits/login/> → and click "Using your Benefits" or Emblem Health (was HIP) <https://www.EmblemHealth.com>

(over)

PLEASE FILL OUT AND RETURN TO: ***Carol Portugal***, BUSINESS OFFICE no later than
10/1/2021

TO: Business Office- Health Insurance
Carol Portugal

FROM: Please Print Name _____

RE: Buyout of Health Insurance

I have read the Health Insurance Buyout provision of the contract (CBA) and wish to avail myself of the option; namely, that I am reimbursed a portion of the premium saved from the District's contribution. ***I understand by signing below I may be asked to furnish a copy of my most recent tax return, as directed by the District's internal auditors, to substantiate my eligibility for family coverage.***

I understand that the option will take effect immediately and that in the event I wish to reenter a plan that re-entry will be subject to the rules and regulations of the District's providers' conditions upon pro-rata reimbursement of any payments made to me pursuant to this provision.

MAKE SURE TO ATTACH A COPY OF THE FRONT AND BACK OF YOUR CURRENT INSURANCE CARD

PLEASE INDICATE YOUR CHOICE:

I WISH TO DECLINE HEALTH INSURANCE (CHECK ONE BELOW):

DECLINE INDIVIDUAL COVERAGE _____

DECLINE FAMILY COVERAGE _____

DATE: _____ SIGNATURE: _____

FAMILY TO INDIVIDUAL* _____

*(To be eligible, you must have elected this option prior to June 30, 2006)

DATE: _____ SIGNATURE: _____

If an initialed copy of this form is not returned to you within one week, please contact ***Carol Portugal*** at 516-434-3062.

For Business Office Use
Initials _____