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 2, 2020

TO: All Employees Eligible for Health Insurance Buyout

FROM: Richard Cunningham
Assistant Superintendent for Business

RE: HEALTH INSURANCE COVERAGE – BUYOUT 2020-2021 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 Celeste Russotto 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 2021 and;
  2) the first pay period of June 2021
- 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: *Celeste Russotto*, BUSINESS OFFICE BY no later than 10/1/2020

TO: Business Office- Health Insurance
Celeste Russotto

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 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.

PLEASE INDICATE YOUR CHOICE:
MAKE SURE TO ATTACH A COPY OF YOUR CURRENT INSURANCE CARD:

I WISH TO DECLINE HEALTH INSURANCE ____________________________________

DATE: ___________________ SIGNATURE: _______________________________

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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 Celeste Russotto at 516-434-3062.

For Business Office Use
Initials ________