

TOWN OF DOUGLAS

VOLUNTARY WAIVER OF HEALTH INSURANCE For Enrollment in Health Insurance Opt-Out Program

In return for the agreement to waive Town group health insurance coverage, the Town agrees to pay an eligible employee one of the following amounts:

(1) \$1,500 per fiscal year for waiving individual health insurance plan coverage

or

(2) \$3,000 per fiscal year for waiving family health insurance plan coverage

The Town will process the above payment in semi-annual installments (\$750 for an employee waiving individual health insurance or \$1,500 for an employee waiving family health insurance) on or about the last pay period in December and June. The semi-annual opt-out payments will be subject to Federal, State, and Medicare taxes.

To be eligible an employee must not have an outstanding court order or agreement requiring the employee to provide health insurance coverage for the employee's spouse, ex-spouse, or dependent children, if any.

To be eligible, an employee must have been enrolled in the Town's Group Health Insurance Plan for a period of at least 12 months immediately prior to applying for the Health Insurance Opt-Out Program. An employee must completely remove themselves as either a subscriber or dependent on the Town's health plan at the time of enrollment in the Health Insurance Opt-Out Program. A Town employee is not eligible for the opt-out payment where the employee opts-out of their individual health plan, and becomes a dependent on their spouse's plan, when their spouse is also a subscriber on the Town's plan.

If an employee is eligible and elects to opt-out of the Town's Group Health Insurance Plan, the Town is not responsible for medical coverage effective on July 1, 2016 (except for medical coverage for injuries and illnesses covered by G.L. c. 41, Sec. 111F or G.L. c. 152) and for each fiscal year thereafter that the employee voluntarily agrees to waive health insurance coverage through the Town.

An employee who wishes to enroll in the opt-out program must return the signed acknowledgement form as well as proof of other health insurance to the Treasurer/Collector's Office by 4:00 pm on Thursday, May 25th, 2016. The Acknowledgement form must be re-submitted on an annual basis. The employee must also provide proof of private health insurance coverage which meets the requirements of MassHealth and the Patient Protection and Affordable Care Act to avoid any penalties to the Town.

An employee is only eligible to re-enroll in the Town's group health insurance plan during the Annual Open Enrollment Period or due to a loss of coverage from a source other than the Town, i.e. a qualifying event under COBRA –

(1) the death of a covered employee; (2) the termination (other than by reason of the employee's gross misconduct), or a reduction of hours, of a covered employee's employment; (3) the divorce or legal separation of a covered employee from the employee's spouse; (4) a covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or (5) a dependent child ceasing to be a dependent child of the covered employee under the generally applicable requirements of the plan and a loss of coverage occurs.

To re-enroll in the Town's Group Health Insurance Plan, the employee must complete the required paperwork during the Open Enrollment Period or, for a loss of coverage, notify the Treasurer/Collector's Office and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.

If an employee does re-enroll in the Town's group health insurance, or the employee's employment with the Town ends (termination, resignation, retirement, reduction of hours, layoff, or death) during the fiscal year, the employee will only be eligible for a pro-rated payment.

Each employee agreeing to opt-out of the Town's Group Health Insurance Plan must acknowledge that they have read and agree to comply with the terms and conditions of the Town's Opt-Out Program on the attached Acknowledgement Form, a copy of which along with any supporting documentation will be placed in the employee's personnel file.

The Town reserves the right to alter or eliminate this program at the conclusion of any fiscal year.

ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I have read and understand the terms of the Town's Health Insurance Opt-Out Program, that I have had the opportunity to ask questions of the Town regarding the Opt-Out Program and inquire of attorneys of my own choosing, and that I am agreeing to waive my right to health insurance coverage through the Town effective July 1, 2016.

Employee Name

Date

Employee Signature

Treasurer/Collector's Department
Representative

Date

Initial Proof of other Health Insurance Attached

