Town of Wakefield
July 1, 2024 - June 30, 2027

VOLUNTARY WAIVER OF HEALTH INSURANCE

For Enrollment in Health Insurance Opt-Out Program

The Town will pay YOU $$$ monthly to drop our Health Insurance
Read the following to see if you qualify

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

(1) $2,100.00 for waiving individual health insurance plan coverage

or

(2) $4,200.00 for waiving family health insurance plan coverage

The Town will make the above payment in 12 monthly installments ($175.00 for an employee waiving individual health insurance or $350.00 for an employee waiving family health insurance) subject to Federal, State, and Medicare taxes.

To be eligible for this Opt-Out Program an employee must meet all of the following Requirements:

1) Remains an active employee of the town of Wakefield covered by one of its health insurance plans for at least six months prior to your enrollment in this program.
2) Provides documentation of alternative comparable health insurance plan coverage from another source.
3) Does 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.
4) Must completely remove itself as either a subscriber or dependent on the Town's health plan. 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 or parent's plan when their spouse or parent is also or becomes a subscriber on the Town's plan.

If an eligible employee elects to opt-out of the Town's health insurance plan, the Town is not responsible for medical coverage (except for medical coverage for injuries and illnesses covered by section 111F or G.L.c.152) during any "opt-out" period.

Retirees on the Town's health plan are not eligible for this Opt-Out Program.

An employee is only eligible to re-enroll in the Town's health insurance plan during the Annual Open Enrollment Period or due to a loss of coverage from the 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 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, the employee must complete the required paperwork during the Open Enrollment Period or, for a loss of coverage, notify the Human Resource Department and complete the re-enrollment process within thirty (30) days of the date of loss of coverage (or when necessary).

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 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 will be placed in the employee's personnel file. This form must be completed every year during open enrollment.

The contract period will be 7-1-24 through 6-30-27 to align with the current PEC agreement.

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 to 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.

_____ _____

Employee Name Date

_____ _____

Employee Signature

_____ _____

Plan Name and Type Termination Date