Amherst Pelham Health Claims Trust

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OPT-OUT INCENTIVE PROGRAM

The employers of the Amherst Pelham Health Claims Trust (APHCT) will pay a set amount of $1,500 per year for an individual and $3,000 per year for a family plan to active employees, who are currently covered by a health insurance plan through the APHCT and opt-out of being covered through our plans and enroll in health insurance elsewhere. You can enroll in the Opt-Out at any time of the year as long as there is a qualifying event.

The guidelines for the Program are:

The Opt-Out incentive is only available to active employees who are currently enrolled in the APHCT's health insurance.

Employees must provide proof that they and, (if applicable, their dependents), are enrolled in another health insurance plan that is not an APHCT plan or a State subsidized plan such as the Health Connector.

The APHCT employer will pay a set waiver incentive amount: $1,500 per year for an individual plan; and $3,000 per year for a family plan upon proof of comparable insurance coverage with another non-APHCT plan.

Employees must have been enrolled in the APHCT employer's health insurance on or before September 1 of the prior calendar year to be eligible.

The APHCT employer will pay the Opt-Out benefit via payroll on a monthly basis, less any required withholdings.

If there is a qualifying event in which an employee who has opted-out needs to opt back onto APHCT insurance, the employee will be allowed to do so as long as it is within 30 days of the qualifying event. Should the employee choose to come back onto an APHCT plan, the Opt-Out payments would cease.

Upon termination of employment, participation in the Opt-Out program will cease. An employee's retirement will be considered a qualifying event for re-enrollment and they will be allowed to do so as long as it is within 30 days of the date of retirement.

The only way to receive the Opt-Out is if the employee is not covered by the APHCT's health plans in any way. This includes through a parent or spouse's plan or changing from a family to individual plan through the APHCT.

If, at a future date, the APHCT decides not to offer the Opt-Out Program anymore, employees will be given an opportunity to get back onto the APHCT's health plans if they choose.

Any issues or disputes that arise regarding enrollment periods or rules and regulations relating to the implementation of the program shall be reviewed by the APHCT's Administrator (Amherst Town Manager) whose determination shall be final and binding.

The employee must acknowledge that their decision to not participate in the APHCT's health plans is made voluntarily.

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Health Insurance Opt-Out Election Form

Please carefully read each side and *PRINT CLEARLY*

Insured Name (First) (MI) (Last)

Street Address

City State Zip Code

APHCT Employer:

☐ Town of Amherst Municipal
☐ Amherst Elementary Schools
☐ Town of Pelham Municipal & School
☐ Amherst Pelham Regional Schools

Type of APHCT coverage: ☐ Individual ☐ Family

Name of APHCT health plan in which you are now enrolled:

☐ Blue Care Elect PPO
☐ Network Blue N.E. HMO
☐ Harvard Pilgrim PPO
☐ Harvard Pilgrim HMO

I understand that in order to participate in the opt-out program, I must be an active employee of one of the APHCT employers and further understand that should my employment be terminated in any manner that my eligibility to participate in the program will terminate as well.

I understand that I must have had continuous coverage by an APHCT health insurance plan for at least Ten (10) months immediately prior to the application for Opt-Out. (i.e., must have had coverage from September 1, 2015 to June 30, 2016 for Opt-Out to begin in July, 2016).

I hereby elect a monetary allowance in lieu of an APHCT sponsored group health insurance plan. I understand that the annual allowance is $1,500.00 for an individual plan and $3,000 for a family plan. The allowance will be paid in equal monthly installments while this election is in effect. The first monthly installment will begin in approximately 60 days from the date the Opt-Out application is approved. I understand that these payments will be treated as income and subject to appropriate withholdings.

I understand that I must maintain my basic life insurance.

My other non-APHCT health insurance coverage is not through a Federal or State sponsored program (such as the Health Connector or Mass Health). I have compared my other non-APHCT health insurance coverage with my APHCT coverage. The coverage is comparable and I can provide proof of coverage for myself and my dependents if they are currently enrolled in the APHCT health plan.

I understand that I may cancel this election (at which time payments will cease) and re-enroll in the APHCT plan only:

- during annual enrollment periods; or
- after involuntary loss of my other coverage through no fault of my own; or
- if a significant change occurs in other health insurance coverage other than premium cost; or
- if a change occurs in family circumstances such as marriage, divorce, birth of a child, or end of spouse's employment; or
- if my employment is terminated by my retirement.

I acknowledge that my decision to participate in the opt-out program is being made voluntarily and in no way affects my employment status.

_____ _____

Signature of Insured Date