



# TOWN OF SAUGUS

HUMAN RESOURCES

298 CENTRAL STREET

SAUGUS, MASSACHUSETTS 01906

Telephone: (781) 231-4142 • Fax: (781) 231-5666

## 2015 Health Insurance Opt-Out Option – Program Terms & Conditions

In an effort to control increasing health insurance costs, the Town of Saugus is continuing a voluntary Health Insurance Opt-Out Option for employees who meet the eligibility requirements. This program will be available to active, benefit-eligible employees, provided the employee can furnish written proof of coverage for themselves and/or dependents with another (non-Town) health insurance carrier, and who have been insured through the Town of Saugus for twenty-four (24) consecutive months. The Town of Saugus will continue to provide existing benefits to those employees who fail to meet the eligibility requirements, or who choose not to take advantage of this program.

An eligible employee who elects to waive his/her health coverage for the upcoming Plan Year must complete an Opt-Out Enrollment Form and provide the Town's Human Resource Office with written proof of other (non-Town) coverage. This form will be available in Human Resources each year during the Annual Enrollment period in spring (April 13 through May 13).

A financial incentive will be paid to each employee who successfully enrolls in the program. The payment, which is subject to Federal, State and Medicare taxes, will be made on an annual basis at the conclusion of the FY16 Plan Year, with the Plan Year running July 2015 through June 2016. Once enrolled in the Opt-Out Program, all health care coverage will terminate as of June 30, 2015.

Financial incentive for waiving INDIVIDUAL health insurance: \$1440

Financial incentive for waiving FAMILY health insurance: \$3600

**In the event an employee must wait for a spouse's Annual Enrollment to sign up for health insurance, the Opt-Out Enrollment Form (along with proof of the spouse's Annual Enrollment dates) must still be submitted to the Human Resource Office during the Town's Annual Enrollment in spring.** Proof of coverage will be required at a later date in order to complete the transition.

Employees wishing to remain in the Opt-Out Program must re-enroll each year. Conversely, those employees who participate in the Opt-Out Program will have the opportunity to re-enroll in the Town's health insurance each year. Re-enrollment during the plan year would also be allowed providing an employee can furnish written proof of loss of coverage elsewhere and notifies HR within 30 days of loss of coverage. In such cases the financial incentive payment will be pro-rated.

Financial incentive payments will also be pro-rated in cases of benefit-eligibility status changes, voluntary/involuntary reduction of hours, etc. Employees must be employed with the Town to receive the incentive payment, thus an employee who resigns or is terminated during the Plan Year will not be eligible for an incentive payment the following July.

Please keep this form for your records.



**TOWN OF SAUGUS**  
 HUMAN RESOURCES  
 298 CENTRAL STREET  
 SAUGUS, MASSACHUSETTS 01906  
 Telephone: (781) 231-4142 • Fax: (781) 231-5666

**Health Insurance Opt-Out Option –Program Enrollment Form**  
*(Submissions will only be accepted April 13, 2015 – May 13, 2015)*

EMPLOYEE NAME \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ DATE \_\_\_\_\_

SOCIAL SECURITY # (XXX – XX – \_\_\_\_ \_\_\_\_ \_\_\_\_ ) PHONE \_\_\_\_\_

**This form must be completed by each employee enrolling in the Health Insurance Opt-Out Program.**

CURRENT HEALTH INSURANCE PLAN:

Individual (*Financial Incentive: \$1440*)       Family (*Financial Incentive: \$3600*)

I HAVE READ AND UNDERSTAND THE OPT-OUT PROGRAM TERMS & CONDITIONS.

I understand that unless I am re-enrolling in the program, I must provide written proof of other (non-Town) health insurance coverage and that my application is not complete until such documentation is submitted. I further understand I must be actively employed by the Town in order to receive the financial incentive.

SIGNATURE \_\_\_\_\_  
*(Forward enrollment form and proof of other coverage to HR (Town Hall) by May 13, 2015)*

FOR OFFICE USE ONLY:

Received by deadline (*May 13, 2015*) \_\_\_\_\_ Yes \_\_\_\_\_ No      Re-enrollment? \_\_\_\_\_ Yes \_\_\_\_\_ No

Secondary Annual Enrollment Period? \_\_\_\_\_ Yes \_\_\_\_\_ No      Dates (*if applicable*) \_\_\_\_\_

Determination: \_\_\_\_\_ Meets Eligibility Requirements      \_\_\_\_\_ Does not meet Eligibility Requirements

24 months Town coverage       Proof of other (non-Town) coverage attached for:  Self       Dependents  
*(if applicable)*

\_\_\_\_\_ Effective Date      \_\_\_\_\_ MIIA/BCBS      \_\_\_\_\_ Payroll      \_\_\_\_\_ Spreadsheet

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_