



Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

To: All Staff
From: Jeff Carlson, Director of Human Resources
Re: Expanded Health Insurance Buy-Out Information – Plan Years 2017-2018 and 2018-2019
Date: April 1, 2018

The 2017-2019 PEC Agreement provides for a buyout of health insurance effective July 1. The District has opted to expand the health insurance buy out option agreement to a monthly basis for plan years 2017-2018 and 2018-2019. Below is a description on how this will work and how others can take advantage of this benefit.

For any health insurance subscriber enrolled on June 30, 2017 or June 30, 2018 who opts to get his/her health insurance from another source, the District will offer an annual cash payout of \$2000 for a family plan and \$1000 for an individual plan for fiscal year 2018 and/or fiscal year 2019. For those who opt out effective July 1 the full payout will be equally divided and paid on September 1 and February 1.

Health Insurance Buy Out Option Information for Plan Year 2017-2018 and 2018-2019:

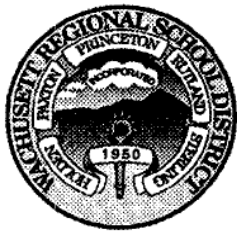
The District will prorate this amount on a monthly basis for those who may opt out on a different month during the plan year 2017-2018 and/or 2018-2019. These payments will be made at 2 and 6 months after the opt out as follows:

- August - Family \$1833.37, Individual \$916.67
- September - Family \$1666.70, Individual \$833.33
- October - Family \$1500.00, Individual \$750.00
- November - Family \$1333.36, Individual \$666.67
- December - Family \$1166.69, Individual \$583.33
- January - Family \$1000.00, Individual \$500.00
- February - Family \$833.35, Individual \$416.67
- March - Family \$666.68, Individual \$333.33
- April - Family \$500.00, Individual \$250.00
- May - Family \$333.34, Individual \$166.67
- June - Family \$166.67, Individual \$83.33

To be eligible for a payout, the buy-out form and proof of other insurance must be returned to Human Resources by the 30th of the month prior to coverage ending.

Attached please find the health insurance buy-out option agreement form for anyone wishing to opt out after July 1.

If you have any questions on the insurance buy-out, please contact me at 508-829-1670 ext 224.



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WACHUSETT REGIONAL SCHOOL DISTRICT
HEALTH INSURANCE BUY OUT OPTION AGREEMENT
PLAN YEARS 2017-2018 and 2018-2019

I, _____ of _____
Member Name Mailing Address

a Wachusett Regional School District Employee/Non-Medicare Retiree, am currently enrolled in the District’s health insurance. In consideration for the sum of \$2000 for family coverage and \$1000 for individual coverage, I do hereby cancel my health insurance coverage for my (self) (family). I understand that my cancellation of coverage in whole or in part, shall be for the period of July 1, 2017 to June 30, 2019. I understand that these payments will cease after fiscal year 2019. I understand that I may not request reinstatement of coverage for fiscal year 2018 or 2019 except in the event of an emergency caused by the loss of health insurance coverage through another source, as described below. Verification of this loss of coverage is required by the School District. Reinstatement of coverage for the succeeding year shall be made in writing to the District no later than April 1 to be effective July 1 of the succeeding fiscal year.

Any enrollee who previously opted out of the District’s insurance under the prior PEC Memorandum of Agreement (2015-2017) and who is still opting out of the insurance will for each of the two years of this Agreement will continue to receive the opt-out payment in accordance with the payout procedures enumerated as stated above.

I further understand that the consideration payment to me shall be subject to all usual payroll deductions and shall be paid in 2 installments, one in September and one in February of the year for which the election is made or 2 and 6 months after a pro-rated termination of coverage. If reinstatement to health insurance coverage occurs during the waived year due to emergency, or I cease to be eligible for health insurance coverage, by termination of employment or other reason, I agree to repay to the District, pro rata, any amount already paid to me as an unused portion of this agreement within thirty days of reinstatement and/or termination of employment.

I understand that:

- Prior to the first day of each plan year, I will be required to complete a new benefit Election Form. My election is effective for the plan year and may be changed during the year only for changes in family status (e.g.,) (marriage or divorce, death of spouse or dependent, adoption or birth of child, or certain changes in spouse’s employment that affect health coverage) that cause the loss of health insurance.

Health Insurance Declination Cash

In accordance with my rights under the plan and this agreement, I elect cash payment for reducing or withdrawing from health coverage as follows (select one):

_____ Family coverage to no coverage _____ Individual coverage to no coverage

Employee/Non-Medicare Retiree Signature Date

Accepted and agreed to by:

District’s Authorized Representative Date