Terms of Medical Plan Cash-in-Lieu Payment

Full year union staff employees eligible to enroll in the Addison Central School District health plan electing to waive coverage under the plan may be eligible for an annual Cash-in-Lieu (CIL) payment of **$1,500**. This CIL payment is $1,500 annually, to any eligible union employee who elects to decline medical insurance coverage, per all applicable state and federal regulations. Such payment shall be paid to the employee on a bi-weekly basis and shall be pro-rated based on FTE. To be eligible for the CIL payment the employee, spouse, if any, and all eligible family members who are tax dependents of the employee must be covered by other permissible group health plan coverage. (Federal tax law prohibits a CIL payment to employees, and/or to their spouse and other family members, covered by an individual policy of health insurance, including individual policies on Vermont Health Connect.

If coverage is provided by a Vermont Public School District, individuals are not eligible for the CIL payment.

Other permissible group health plan coverage:

(a) another employer's group plan
(b) a spouse's health benefit plan, or
(c) certain governmental plans, such as Medicare Part A, CHIP (Children's Health Insurance Program), Medicaid, and most TRICARE coverage for military veterans.

Employees are required to certify the employee, spouse and any dependents eligible under the Addison Central School District plan are all enrolled in other permissible health plan coverage. ACSD has the discretion to determine whether an employee must provide proof of other medical plan coverage. Proofs of enrollment in other medical plan coverage include member identification cards, a letter from an insurance company or health plan, a copy of enrollment information, or a letter from another employer attesting to enrollment in that employer's health plan. All proof of enrollment must show the applicable coverage period.

Employees who do not provide the required certification or required proof by **November 15, 2023** will not be eligible to receive the CIL payment for the plan year.

The employee must provide the certification of other medical coverage within the following deadlines:

- New hires must provide the certification of other permissible group medical coverage within 30 days of hire.
- At annual enrollment, the certification of other medical coverage must be provided by **November 15, 2023**.
- If an employee or employee's family member experiences a Special Enrollment or other change in status (explained below) and the employee then makes a mid-year election to waive coverage under the ACSD plan consistent with Employer's cafeteria plan, notice and proof of enrollment must be provided within 30 days to be eligible for the CIL payment. The biweekly CIL payments will begin for the first calendar month coverage terminates, provided the change in status is approved and the certification is accepted.

To obtain the monthly CIL payment, a full-time employee must also complete and sign the attached certification form.

Group Medical Plan Waiver Form for Plan with Conditional Cash-in-Lieu Payment

Name _____

Your next opportunity to enroll in medical coverage will be during the plan's annual enrollment period each year, generally held during the month of November with coverage effective the following January, unless you qualify for a special enrollment (see below).
In addition to special enrollment rights, you may be able to enroll in the plan if you experience certain "change in status" events that are permitted by the IRS and under the terms of the ACSD Plan.

Status changes that will permit you to enroll in our plan are:

1. Changes in Marital Status

- ✓ Marriage
- ✓ Divorce or annulment
- ✓ Legal separation
- ✓ Death of spouse

2. Changes in Number of Dependents

- ✓ Birth
- ✓ Adoption or placement for adoption
- ✓ Death of dependent

3. Change in Employment Status That Affects Coverage Eligibility

	You	Spouse or Dependent
Termination of employment	✓	✓
Commencement of employment	✓	✓
Part-time to full-time	✓	✓
Full-time to part-time	✓	✓

4. Changes in Dependent's Eligibility under an Employer's Plan

Lost eligibility (e.g., due to age, student status, marital status)	✓
Gained eligibility (e.g., due to age, student status, marital status)	✓

5. Changes in Residence Affecting Eligibility

You	Spouse or Dependent
✓	✓

6. Certain court orders, Medicare or Medicaid

You	Spouse or Dependent
✓	✓

See Summary Plan Description for details.

Group Medical Plan Waiver Form for Plan with Conditional Cash-in-Lieu Payment

Special Enrollments

If you are declining enrollment for yourself and/or your tax dependents (including your spouse) because of other group medical coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. In addition, in order to claim special enrollment rights for you and your dependents, you must complete this form indicating that the other coverage is the reason you are waiving coverage under this plan **and** you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

Finally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependent(s), even if you waived all coverage under the health plan for your entire family. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request a special enrollment or obtain more information, please contact Gail Leach, Human Resource Coordinator at 382-1281 or gleach@acsdvt.org.

Cash-in-Lieu Payments

To be eligible for the CIL payments offered by your employer if you waive all medical coverage under the plan, you must attest that you *and your tax dependents* are enrolled in other permissible group health coverage that is not individual medical insurance.

I elect to waive medical plan coverage and receive a Cash-in-Lieu payment. I have listed the other permissible health plan coverage in which my eligible family members (tax dependents, including spouse, if applicable) and I am/are enrolled.

Family Member	Name	Coverage Name	Effective Date
Employee			
Spouse			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			

(If you have additional dependents, please use the reverse side of this form to enter the information requested above.)

I understand that by not enrolling in plan coverage now, the opportunity to enroll later is limited as explained above. I also understand my eligibility to receive the CIL payment requires my family members (spouse and tax dependents) and I ***remain enrolled in other permissible group health plan coverage*** (that is not individual health insurance). I agree to notify *Gail Leach at 382-1281 or gleach@acsdvt.org* within 30 days if *one or more of my family members or* I lose the coverage identified above.

Signature _____ **Date** _____