CITY OF CHELSEA, MA
Human Resources Department

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Health Insurance Benefit Option Program Policy

Employees currently enrolled in the City of Chelsea's (the "City") health insurance plans may be compensated for not participating in the City's health insurance programs.

ELIGIBILITY

1. Health Insurance Benefit Option ("HIBO") Program Summary:
   The HIBO program offers a financial incentive to active employees who elect to waive health insurance by meeting the eligibility requirements below.

2. Benefit Eligibility (This includes Union and Non-Union City and School employees):
   a. Employees must be active and eligible for health insurance benefits through the City.
   b. Employees must be able to prove they have one of the City's health insurance plans.
   c. The employee's health insurance must be uninterrupted coverage for a period of three to five (3-5) years.
   d. Employees must show proof of coverage outside of the City's sponsored health plans.
      i. Employees cannot participate in the City's health insurance plans based on their own work, or the work of another subscriber employed by the City, or through a retiree.

3. Proof of Other Coverage:
   An employee must show proof of coverage outside one of the City's sponsored health plans before participating in HIBO. Employees must fill out the State Health Insurance Responsibility Disclosure ("HIRD") form and other necessary forms each year during the City's open enrollment period.

ENROLLMENT

1. Enrollment:
   a. Employees may apply for the HIBO program during the City's annual open enrollment period providing you meet eligibility.
   b. Employees may waive their health insurance coverage during their spouse's open enrollment.

2. HIBO Re-enrollment:
   Employees previously enrolled in HIBO and wish to re-enroll, must meet Eligibility criteria during re-enrollment.

3. Qualifying Events:
   Employees may waive their health insurance outside the City's open enrollment period if they have a qualifying event. A qualifying event includes, but is not limited to, change in marital status; birth, adoption or legal guardianship; change in employment status that affects employee's benefits; employee becomes disabled; employee or dependent becomes eligible for Medicare or Medicaid; or death. Employees must contact the Human Resources Department within thirty (30) days of the qualifying event and provide all necessary documentation.

RE-ENROLLMENT IN THE CITY'S HEALTH INSURANCE PLAN

An employee enrolled in the HIBO program may re-enroll in one of the City's health insurance plans under the following criteria:

1. The City's annual open enrollment period.
2. Qualifying events such as, but not limited to, change in marital status; birth, adoption or legal guardianship; change in employment status that affects employee's benefits; employee becomes disabled; employee or dependent becomes eligible for Medicare or Medicaid; or death. Employees must contact the Human Resources Department within thirty (30) days of the qualifying event and provide all necessary documentation.

HIBO PAYMENT

1. HIBO shall be payable by November 30th each year for those eligible in the prior fiscal year.
2. Employees with uninterrupted coverage for five (5) years or more, will receive the full benefit amount of fifteen-hundred dollars ($1,500) for an individual plan or three-thousand ($3,000) dollars for a family plan on an annual basis. *Refer to HIBO Payment #4 for initial payment.*
3. Employees with uninterrupted coverage for a minimum of three (3) years, but less than five (5) years, will receive a permanently-prorated-amount on an annual basis.
4. The initial payment may be prorated based on the enrollment date, whereas subsequent payments will reflect a full fiscal year.
5. Such payment shall be subject to deductions for state and federal taxes and other deductions required by law or authorized by the employee.
6. Such incentive payment shall not be considered part of or included in the employee's base pay.

The City reserves the right to modify, amend or discontinue the Health Insurance Benefit Option Program.

Health Insurance Benefit Option Program
Voluntary Waiver Form

City ☐ **School** ☐

I _____, agree to waive the City of Chelsea's (the "City") health insurance coverage and meet the eligibility requirements as indicated in the Health Insurance Benefit Option ("HIBO") Program Policy.

Effective Coverage Date (*original date of uninterrupted coverage*): _____

Voluntary Cancellation Date (*original date of cancellation*): _____

In return for my election to waive the health insurance coverage, the City agrees to pay me as indicated in the HIBO Policy.

- I hereby certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse, dependent children or any other party.

- I understand that the City is not responsible for my medical coverage effective on (*original date of cancellation*) _____ (except for medical coverage for injuries and illnesses covered by M.G.L.ch. 41, § 111F & 100 or M.G.L.ch. 152) and for each fiscal year thereafter, I voluntarily agree to waive the City's health insurance coverage.

- I hereby acknowledge that I am only eligible to re-enroll in the City's health insurance plans during the annual open enrollment period; or during a qualifying event as indicated in the HIBO Policy, and I must contact the Human Resources Department within thirty (30) days of the qualifying event and provide all necessary documentation, and complete the re-enrollment process.

- I acknowledge that I will only be eligible for a prorated payment based on the following criteria: if I enroll or re-enroll in the City's health insurance after the fiscal year begins (July 1); if my employment with the City ends; or if my hours are reduced below 20 hours per week during the fiscal year. Proration will be calculated through the date prior to re-enrollment; separation from employment; or reduction in hours.

- I acknowledge that I have read and agree to comply with the terms and conditions of the City's HIBO Program.

Phone: _____ Email: _____

Print Name: _____ Dept.: _____

Signature: _____ Date: _____