MANCHESTER SCHOOL DISTRICT
SCHOOL ADMINISTRATIVE UNIT NO. 37
195 McGregor Street, Suite 201
Manchester, NH 03102
Telephone: 603.624.6300 • Fax: 603.624.6337

MEA Waiver Form

I received and read a copy of the "Notice of HIPAA Special Enrollment Rights" (the Notice) at or before the time I was initially offered enrollment in Manchester School District Group Health Plan (the Plan). I am aware of the warning in the Notice that I will lose some special enrollment rights for myself and my dependents if I decline coverage because I or my dependents have other coverage, unless I give the Plan this written statement that the reason I am declining coverage is because I or my dependents have other coverage.

I am also aware that under the Individual Mandate of the Federal Affordable Care Act, all legal residents of the United States are required to have health insurance. Failure by me, my spouse and/or my dependents to have and maintain health insurance could result in a penalty from the IRS.

By signing this form, I decline coverage under the Manchester School District Group Health Plan for the people listed below. My reason for declining coverage for these people is that they have other coverage under another group health plan or health insurance.

I further acknowledge that by declining coverage, absent a valid HIPAA special enrollment event, I will be excluded from enrolling in the Manchester School District Health plan until the next open enrollment.

(List all the people whom you could cover under the Plan but are not covering because they have other coverage, including you, your spouse and/or your dependents. Use additional paper if necessary.)

Name	Relationship (Self, Spouse, Dependent)	Source of Other Coverage (Spouse's plan, Medicaid, etc.)

MEDICAL:

❑ I **DO NOT** wish to enroll in medical insurance coverage at this time. I may enroll during the next open enrollment, or when I have a qualifying event. I understand it is my responsibility to contact the Human Resources within 30 days of a qualifying event. I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for

the period from July 1, 2016 to June 30, 2017. I have read the above and I understand the consequences of my waiver of coverage.

Article 6.F The School District will pay four thousand dollars ($4,000.00), per full plan year (July 1 through June 30), prorated for non-enrollment of less than one plan year (not available to those who have received HSA contributions in the same plan year), to any bargaining unit member who declines to exercise his/her right to health insurance coverage under the School District's or City's plan and who also provides satisfactory evidence that he/she has valid alternative health insurance coverage elsewhere (alternate coverage must not be through the School District or the City of Manchester), provided the number of new employees opting out (as compared to the number of employees that opted out in the FY2016 plan year) makes the increase in the opt out payment cost neutral or positive to the District for that year. An additional 40 teachers would have to opt out in addition to the 120 currently opting out. If an employee selects this option, he/she shall not be entitled to re-enroll except during the next annual open enrollment period, except if the employee encounters a "qualifying event." Such opt out payment shall be paid during the last pay period of the school year. You do not need to opt out of dental coverage in order for this incentive to apply.

In the event that the District does not obtain "cost neutral or positive" in the first year of the agreement, criteria: The number of new employees opting out (as compared to the number of employees that opted out in the previous plan year) makes the increase in the opt out payment cost neutral or positive to the District for that year. A total of 160 teachers opting out will be required to be "cost neutral" in the first three years of the contract. Thereafter, the 160 threshold is no longer applicable provided cost neutrality has been established in the prior year.

If a member opts out and then is notified that the District did not meet the threshold for "cost neutral or positive" for the applicable year, that bargaining unit member shall have the opportunity to reenroll in the health insurance and select a plan offered by the District. A unit member is eligible for this incentive each year provided the applicable threshold for payment is met.

DENTAL

☐ I **DO NOT** wish to enroll in Dental Insurance at this time. I may enroll during the next open enrollment, or when I have a qualifying event. I understand it is my responsibility to contact the Human Resources within 30 days of a qualifying event.

This opt out election will stay in effect until you make an alternative election.

Signature: _____

Print Your Name: _____

Date Signed: _____

** Please enclose a proof of insurance letter.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Human Resources
Address	195 McGregor Street, Suite 201,
City, State	Manchester, NH 03102
Telephone	603-624-6300