Employees eligible to enroll in the *Enter name of group health plan* electing to waive coverage under the plan may be eligible for an annual Cash-in-Lieu (CIL) payment of *Enter name of group health plan*. This CIL payment is *insert prorated language and monthly amount or lump sum language agreed to in collective bargaining where applicable*.

**Please note** - the language below includes a requirement that employee certify appropriate coverage for the entire **tax family**. The language in green should be removed or modified if the district is eligible for the safe harbor provision and is waiting until the end of the safe harbor period (yet to be announced) before instituting this practice.

Be aware, however, that the safe harbor does **not** eliminate the need to consider whether the CIL payment is “incidental” or the need to include the CIL payment in wages for overtime and other benefits. Only tax family certification provides this relief.

**Employers remove this text box prior to using this form.**

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. Vermont Law prevents CIL payment to public school employees, when covered as a dependent under another public school.

*Other permissible group health plan coverage:*

1. *another employer’s group plan; however, employees will not be eligible for a CIL payment if the employee is simultaneously receiving health care benefits from the same or another school employer,*
2. *a spouse’s health benefit plan (unless the spouse’s health benefit plan is through another school employer), or*
3. *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 *Enter name of employer group health plan* are *all*/is enrolled in other permissible health plan coverage. *Enter employer name* 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 *Enter date information must be received* will not be eligible to receive the CIL payment for the plan year.

The employee must provide the certification of other medical coverage (certification form attached) within the following deadlines:

* New hires must provide the certification of other permissible group medical coverage within *Enter number of days* days of hire.
* At annual enrollment, the certification of other medical coverage must be provided by *Enter date/timing certification must be received*.
* 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 *Enter name of group health plan* consistent with Employer’s cafeteria plan, notice and proof of enrollment must be provided within *Enter number of days following event* days to be eligible for the CIL payment. The monthly 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.

**Name Employee #**

You now have the opportunity to enroll for group medical plan coverage in the *Enter name of medical plan*. If you do not enroll yourself and any eligible dependents by *Enter date enrollment period ends*, your next opportunity to enroll will be during the plan’s annual enrollment period each year, generally held during the month of *Enter month open enrollment is generally conducted* with coverage effective the following *Enter date coverage effective following open enrollment*, unless you qualify for a special enrollment (see below).

*If employer sponsors a cafeteria plan and/or otherwise allows mid-year enrollment changes other than special enrollment, include and customize this section.*

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 *Enter name of medical plan.*

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

**1. Changes in Marital Status**

1. ✓ Marriage
2. ✓ Divorce or annulment
3. ✓ Legal separation
4. ✓ Death of spouse

**2. Changes in Number of Dependents**

1. ✓ Birth
2. ✓ Adoption or placement for adoption
3. ✓ 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.***

**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 *enter number of days (usually 30 or 31 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 *enter number of days (usually 30 or 31*) days after the marriage, birth, adoption or placement for adoption. To request a special enrollment or obtain more information, please contact *insert name, title, telephone number, and any additional contact information of the appropriate plan representative*.

**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; in addition, you are not eligible to receive the CIL payment if you are simultaneously receiving health care benefits from the same or another school employer.**

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 *Enter contact person and contact information* within *Enter time frame* if *one or more of my family members or* I lose the coverage identified above.

**Signature Date**