

**West New Board of Education  
Medical Voluntary Financial Incentive  
Effective: January 1, 2010**

**Policy:** In an effort to control increasing health insurance costs, West New York Board of Education is implementing a Voluntary Medical Financial Incentive program for all eligible active employees. The program will be made available to any employee who can provide the Board of Education with written proof of coverage for themselves, or their spouse and dependents through another carrier. The Program is strictly voluntary. The Board of Education will continue to provide any and all benefits bargained for to all eligible employees who do not opt to take advantage of the this Program.

This program will be implemented on a one year basis. The Board of Education reserves the right to discontinue the program at the end of one year or thereafter, at its discretion.

**Procedure:** An eligible employee electing to change his/her coverage must complete a member Waiver of Coverage Form and supply the Board of Education with written proof of other current coverage for the employee and/or his or her spouse and/or dependents. This form is available in the Personnel Office and releases the Board of Education from any/all responsibility for medical claims incurred for non-insured dependents and/or for yourself, whichever is applicable.

Upon completion of the member Waiver of Coverage Form, the Personnel Office will process a Personnel Action Form for the appropriate financial incentive amount.

**AMOUNT OF FINANCIAL INCENTIVE:** The amount of the financial incentive will be 50% of the premium amount saved by the Board of Education because of the voluntary waiver.

**VALID WAIVER OPTIONS INCLUDE:**

1. An employee who is eligible for Family or Husband/Wife coverage and who elects to cancel ALL insurance.
2. An employee who is eligible for Family or Husband/Wife coverage and who elects to cancel all dependents and retain Single coverage.
3. An employee who is eligible for Family coverage and who elects to cancel spouse's insurance and retain Parent/Child insurance.
4. An employee who is eligible for Parent/Child coverage and elects to cancel ALL insurance.
5. An employee who is eligible for Parent/Child coverage and elects to cancel all dependents and retain Single coverage.
6. An employee who is eligible for Single coverage and elects to cancel ALL insurance.

**PAYMENTS:** Payments will be made on an annual basis as follows:

For the 12 month period the employee will be paid by the 31<sup>st</sup> of August for the year that the employee has participated in this annual program. "The Year" runs from July 1 – June 30.

EMPLOYEES WHO TERMINATE: Employees who terminate employment will receive the amount reflected above through the last day of the month in which they terminate on a prorated format. Payment will be made only once each August 31<sup>st</sup>.

MID YEAR EMPLOYMENT/COVERAGE ELIGIBILITY: Employees who become eligible for medical coverage mid year because of new employment will receive the amount reflected above on a prorated format. Eg., this incentive is a yearly program which runs from July 1 – June 30. The prorated format then will be based upon the number of full months that the employee participated in this annual program during each July 1 – June 30 period. Payment will be made only once each August 31<sup>st</sup>.

RE-ENROLLING: Employees and/or dependents who cease to be covered by their other health coverage (e.g., non-Board of Education coverage) as a result of loss of employment or another triggering event as defined by the Internal Revenue Code, must notify the Personnel Office immediately in writing. Coverage will be retroactive to the date of loss *providing the following requirements are met:*

1. Employee completes a group insurance enrollment application in the Personnel Office within 60 days of the loss of other health coverage\*.
2. Employee provides written proof of loss of other health coverage. Proof must be for the other health identified on the Member Waiver of Coverage Form.

*\*If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll. Open enrollment is the month of October every year.*

Should the Board of Education discontinue this Program, it shall afford employees the opportunity to re-enroll in a medical plan under the same terms and conditions applicable to the other employees.

**West New York Board of Education  
Personnel Office**

**Member Waiver of Coverage Form**

EMPLOYEE NAME: \_\_\_\_\_ (please print legibly)

SOCIAL SECURITY #: \_\_\_\_\_

THIS FORM MUST BE COMPLETED AND SIGNED BY EACH EMPLOYEE WHO ENROLLS IN THE VOLUNTARY MEDICAL FINANCIAL INCENTIVE PROGRAM. COMPLETION IS REQUIRED BY THE NEW ENROLLEE AND BY THE CURRENT ENROLLEE WHO DURING OPEN ENROLLMENT ELECTS TO CONTINUE PARTICIPATION IN THE MEDICAL VOLUNTARY INCENTIVE PROGRAM FOR ANOTHER YEAR.\*

I UNDERSTAND THE OPTIONS AVAILABLE TO ME AS EXPLAINED IN THE ACCOMPANYING POLICY STATEMENT. I HAVE INDICATED MY CHOICE BELOW.

\_\_\_ I am currently eligible for Family or Husband/Wife coverage in the West New York Board of Education Medical program and I elect to decline ALL Medical coverage. My dependents and I are insured with the health insurance program listed below.

\_\_\_ I am currently eligible for Family or Husband/Wife coverage in the West New York Board of Education Medical program and I elect to decline ALL DEPENDENT Medical coverage and retain SINGLE Medical coverage. My dependents are insured with the health insurance program listed below.

\_\_\_ I am currently eligible for Family coverage in the West New York Board of Education Medical program and I elect to cancel spouse's Medical coverage and retain Parent/Child Medical coverage. My spouse is insured with the health insurance program listed below.

\_\_\_ I am currently eligible for Parent/Child coverage in the West New York Board of Education Medical program and I elect to cancel ALL Medical coverage. My dependents and I are insured with the health insurance program listed below.

\_\_\_ I am currently eligible for Parent/Child coverage in the West New York Board of Education Medical program and I elect to cancel all dependent Medical coverage and retain Single Medical coverage. My dependents are insured with the health insurance program listed below.

\_\_\_ I am currently eligible for Single Medical coverage and I elect to cancel ALL Medical coverage. I am insured with the health insurance program listed below.

*\* Participation in the Voluntary Incentive program assumes that the program continues to be offered. This program is offered on a one year basis with the Board of Education reserving the right to discontinue the program at the end of one year or thereafter at its discretion.*

I am declining medical coverage as indicated above because medical coverage is provided to me and/or my dependent through \_\_\_\_\_ (insured's name) whose social security # is \_\_\_\_\_. This insurance is provided through \_\_\_\_\_ (employer's name), and the name of insurance company is \_\_\_\_\_ and policy number of the insurance company is \_\_\_\_\_.

I understand that if I decline coverage through the West New York Board of Education at this time and I lose my "other health coverage" as a result of loss of employment or another triggering event (as defined by the Internal Revenue Code), I must notify the Office of Personnel in writing immediately. I must also complete a group insurance application and submit to the Personnel Office within 60 days of the date the triggering event occurs, and must provide written proof that I/we are no longer eligible for the insurance identified above. Furthermore, I understand that my insurance as an employee of West New York Board of Education will be retroactive to the date of loss providing I have complied with the aforementioned conditions.

I further understand that if I decline coverage at this time, I will not be eligible to re-enroll until an open-enrollment period, unless an involuntary event as noted above occurs which results in my being ineligible for the "other health coverage".

\_\_\_\_\_  
EMPLOYEE NAME (please print)

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

FOR PERSONNEL OFFICE USE ONLY:

Effective date of Decline: \_\_\_\_\_

Financial Incentive Amount: \_\_\_\_\_

C: Employee File  
Voluntary Financial Incentive File

**FOR EMPLOYERS WHO OFFER THE EMPLOYEE PRESCRIPTION DRUG PLAN  
OR A PRIVATE PLAN**

Dept of Treasury - Division of Pension and Benefits  
NJ School Employees' Health Benefits Program  
Local Monthly Active Group - Education Employers  
Rates Eff. 1/1/2010 - 12/31/2010

**Full Time Employees**

Plan/Coverage Description	Employer Single Cost	Dependent Cost	Monthly Total	Annual Total	50% Opt Out Incentive
<b><u>NJ Direct 15-#150</u></b>					
Single	\$438.55	----	\$438.55	\$5,262.60	\$2,631.30
Member & Spouse/Partner	\$440.13	\$546.58	\$986.71	\$11,840.52	\$5,920.26
Family	\$440.70	\$655.65	\$1,096.35	\$13,156.20	\$6,578.10
Parent/Child	\$439.24	\$174.71	\$613.95	\$7,367.40	\$3,683.70
<b><u>NJ Direct 10 -#050</u></b>					
Single	\$460.67	----	\$460.67	\$5,528.04	\$2,764.02
Member & Spouse/Partner	\$462.25	\$574.24	\$1,036.49	\$12,437.88	\$6,218.94
Family	\$462.82	\$688.85	\$1,151.67	\$13,820.04	\$6,910.02
Parent/Child	\$461.36	\$183.55	\$644.91	\$7,738.92	\$3,869.46
<b><u>Aetna, Inc - #019</u></b>					
Single	\$435.16	----	\$435.16	\$5,221.92	\$2,610.96
Member & Spouse/Partner	\$436.74	\$542.38	\$979.12	\$11,749.44	\$5,874.72
Family	\$437.31	\$650.61	\$1,087.92	\$13,055.04	\$6,527.52
Parent/Child	\$435.85	\$173.38	\$609.23	\$7,310.76	\$3,655.38
<b><u>CIGNA Healthcare HMO -#020</u></b>					
Single	\$439.51	----	\$439.51	\$5,274.12	\$2,637.06
Member & Spouse/Partner	\$441.09	\$547.82	\$988.91	\$11,866.92	\$5,933.46
Family	\$441.66	\$657.12	\$1,098.78	\$13,185.36	\$6,592.68
Parent/Child	\$440.20	\$175.12	\$615.32	\$7,383.84	\$3,691.92