

**MOHELA
OPT OUT INCENTIVE PROGRAM
January 2024 – December 2024**

MOHELA will continue to offer Opt Out Incentives if you elect to waive your medical coverage from MOHELA, obtain medical coverage with another group medical plan, and provide MOHELA with the required documents. During open enrollment, Opt Out information needs to be completed and returned to the Human Resources Department.

You must waive your medical coverage from MOHELA.

The medical coverage you obtain must be with a group plan such as those offered by a school, an employer, or other “group.”

In general, a group medical plan is a plan offered by an employer or employee organization that provides medical coverage to employees and their families.

Not eligible: Individual medical insurance is coverage that is purchased on an individual or family basis, and is not being offered by a school, employer or other “group.” *Coverage from the Marketplace or the Exchange is individual medical insurance.* MOHELA does not offer Opt Out Incentives for other medical coverage with an individual plan.

Opt Out Incentive Overview

Employees currently on MOHELA’s group medical insurance will receive up to a one-time incentive of \$3,500.00 for Opting Out along with additional bi-weekly incentives per pay period. Opt Out Incentives are outlined in the following chart:

Current Medical Coverage Level	Make the following Election Choices for Plan Year January 1 – December 31, 2024	Receive the following Incentive
Any level of medical coverage (employee only, employee/spouse, employee/children, family coverage) on MOHELA’s group plan	<ol style="list-style-type: none"> 1. Completely Opt Out of MOHELA’s medical coverage; 2. Provide proof of minimum essential group coverage; 3. Other coverage may not be coverage in the individual market, whether or not it is obtained through the Marketplace; and 4. Complete the MOHELA Medical Benefits Opt Out Attestation Form 	One time incentive of \$3,500 plus the applicable bi-weekly Opt Out Incentive per pay period
Family medical coverage on MOHELA’s group plan	Change coverage level to employee only	One time incentive of \$1,500
Employee/Spouse medical coverage on MOHELA’s group plan	Change coverage level to employee only	One time incentive of \$1,000
Employee/Children medical coverage on MOHELA’s group plan	Change coverage level to employee only	One time incentive of \$1,000

Current Medical Coverage Level	Make the following Election Choices for Plan Year January 1 – December 31, 2024	Receive the following Incentive
Currently not a MOHELA insurance eligible employee (in most cases a newly hired employee)	<ol style="list-style-type: none"> 1. Completely Opt Out of MOHELA’s medical coverage; 2. Provide proof of minimum essential group coverage; 3. Other coverage may not be coverage in the individual market, whether or not it is obtained through the Marketplace; and 4. Complete the MOHELA Medical Benefits Opt Out Attestation Form 	<p>One time incentive of \$2,500 plus the applicable bi-weekly op-out incentive per pay period</p> <p>PLUS \$100-\$150 additional per pay period.</p>
Participating in the Opt Out Incentive program prior to January 1, 2024 with a group plan	<p>To continue to receive the applicable bi-weekly Opt Out per pay period you must:</p> <ol style="list-style-type: none"> 1. Completely Opt Out of MOHELA’s medical coverage; 2. Provide proof of minimum essential group coverage; 3. Other coverage may not be coverage in the individual market, whether or not it is obtained through the Marketplace; and 4. Complete the MOHELA Medical Benefits Opt Out Attestation Form 	Continue to receive the applicable bi-weekly Opt Out Incentive per pay period

Bi-Weekly Opt Out Incentives

- If Opting Out of medical, dental and vision coverage you will receive \$150.00 per pay period.
- If Opting Out of medical but keeping dental and/or vision you will receive \$100.00 per pay period.

Opt Out Incentive Required Documents

To enroll into MOHELA’s Medical Benefits Opt Out Incentive Program, the following must be completed and submitted to Human Resources:

- MOHELA Opt Out Incentive Attestation form.
- A copy of your group medical insurance card or other valid documentation to verify coverage on another group medical plan as of the Opt Out effective date.

MOHELA
OPT OUT INCENTIVE ATTESTATION
January 2024 – December 2024

Name (please print): _____ Opt Out Effective Date: _____

Opt Out Incentive Election

Employees must attest below that they are covered under other medical insurance coverage as of the Opt Out effective date, to be eligible for the Opt Out Incentive.

CHECK ONE for January 1, 2024 – Dec 31, 2024:

I am electing or continuing to Opt Out of all medical/dental/vision coverage in exchange for a \$150.00 taxable amount per pay period (equivalent to \$325 per month).

I am electing or continuing to Opt Out of medical and vision but will keep dental coverage for a \$100.00 taxable amount per pay period (equivalent to \$216.67 per month).

I am electing or continuing to Opt Out of medical and dental but will keep vision coverage for a \$100.00 taxable amount per pay period (equivalent to \$216.67 per month).

I am electing or continuing to Opt Out of medical coverage but will keep dental and vision for a \$100.00 taxable amount per pay period (equivalent to \$216.67 per month).

Proof of other group medical insurance information must be provided (attach copy of medical insurance card).

Opt Out Incentive Attestation

I ATTEST TO THE FOLLOWING:

- I am covered under another group medical plan that is in effect as of the Opt Out effective date and have provided my alternate medical plan information.
- I understand that I must promptly report changes to information I have provided above which may impact my eligibility.
- I understand that this election is for 2024.
- I have read the Opt Out Incentive Eligibility/Terms and Conditions on the following page.

As of the effective Opt Out date, I will have group medical coverage obtained through the following group: (list name of Employer, Military, Medicare, Medicaid etc that you are providing proof of coverage through): _____

Employee’s Signature: _____

Date (required): _____

MOHELA
OPT OUT INCENTIVE ATTESTATION
January 2024 – December 2024

Opt Out Incentive Eligibility

Employees who can demonstrate and attest to having other group medical insurance may elect to Opt Out of MOHELA's medical insurance plans. Employees who elect to Opt Out will receive an incentive for waiving coverage. The applicable amounts will be credited to bi-weekly paychecks as taxable income over the calendar year.

There are typically two circumstances when employees may elect to Opt Out of coverage; as newly eligible for the Opt Out Incentive and, for currently enrolled employees during the annual open enrollment period. Only employees who experience a qualifying event will be allowed to withdraw their Opt Out election and enroll in MOHELA's medical insurance plan mid-year.

You will not qualify for the Opt Out Incentives without completing this form, signing, and dating it. By signing this form you certify that you have read and understand the MOHELA Medical Opt Out Incentive Program Terms and Conditions outlined below.

The medical coverage you obtain must be with a group plan such as those offered by a school, an employer, or other "group."

Individual medical insurance is coverage that is purchased on an individual or family basis, and is not being offered by a school, employer or other "group." *Coverage from the Marketplace or the Exchange is individual medical insurance.* MOHELA does not offer Opt Out Incentives for other medical coverage with an individual plan.

In general, a group medical plan is a plan offered by an employer or employee organization that provides medical coverage to employees and their families.

Opt Out Incentive Terms and Conditions

Please note that this program does not create an employment contract or condition of employment.

Right to request documentation: MOHELA has the right to request documentation from an employee who declares they or any other member(s) of their family have other coverage to prove the existence of medical coverage.

Recourse for making a false statement: An employee who intentionally falsifies his/her medical coverage status or that of their dependents on this form will be subject to immediate repayment of paid incentives and may be released from employment for intentional falsification of employment-related paperwork.

This form is invalid if it is not signed and submitted to HR with a copy of your medical insurance card. This form is unnecessary if you are unable to provide other proof of medical coverage.